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PRECEPTORSHIP IN THE CLINICAL EDUCATION OF SENIOR STUDENT NURSES: REFLECTIONS ON THE RELEVANCE OF A CANADIAN PRACTICE FOR THE GHANAIAN CONTEXT

BY

MARY AMA OPARE

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **PRECEPTORSHIP IN THE CLINICAL EDUCATION OF SENIOR STUDENT NURSES: REFLECTIONS ON THE RELEVANCE OF A CANADIAN PRACTICE FOR THE GHANAIAN CONTEXT** submitted by **MARY AMA OPARE** in partial fulfilment of the requirement for the degree of **MASTER OF NURSING.**

DEDICATION

This thesis is dedicated to my family, who has always encouraged and supported me through my academic endearvours. I am very grateful for their continual prayers.

ABSTRACT

Nursing education in Ghana followed the curriculum of the General Council of England and Wales at the beginning of formal nursing education in 1945. Nursing students were used to give service in the hospital with clinical nursing education following an apprenticeship model. With the introduction of the Comprehensive Nursing Program in 1970, nursing students assumed full student status and this compelled nurse educators to take on additional roles as clinical instructors. Due to increased student-tutor ratios in the clinical setting, students do not get adequate clinical supervision. Nursing administrators complain that nurses trained in the new program are not capable of competent patient care. In response, the Ministry of Health has introduced a one year orientation program to upgrade the clinical skills of the nurses. With recent global economic crises and cut-backs, it is possible that a preceptorship model, which is a one-on-one reality-based clinical experience in which a staff nurse supervises the learning experience of a specific senior level student, could be a substitute for the orientation program. This is a common model in North American nursing education programs. This research study was a descriptive exploratory qualitative study to ascertain the role of the preceptor and the factors that facilitate or inhibit preceptorship from the perspectives of preceptors, faculty, and students. The study groups identified seven primary roles of the preceptor as: orientation of students; socialization of students; teaching of students; inspiration and support for students; evaluation of clinical competence of students; role model; and as an alliance for job opportunities for students. Open lines of communication, faculty commitment and familiarity with site, preceptor willingnesss to take a student and motivated students with

adequate knowledge base are some of the factors that have been identified to facilitate preceptorship. Last minute placement of students, and personality conflicts between preceptors and students were described as inhibiting preceptorship. Issues related to preceptor selection, preceptor reward, benefit of preceptorship and preparation of preceptors emerged as having great impact on preceptorship. Findings of this study have been carefully examined in relation to the possibilities for implementation of a preceptorship program in nursing education in Ghana.

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CHAPTER ONE

Setting the Context: Why Study Preceptorship?

As professional roles in nursing have evolved, there have been changes in nursing education. What was once a technical, procedure-based apprenticeship has become a profession with a research-based practice. The purpose of the research, grounded in practice, is to ensure quality care. Research regarding the educational programs of such professionals is needed. While much nursing education research has been done in Northern countries, it is rare in countries defined as being from the South. As a graduate student in Canada who has more than twenty years of experience teaching nursing in my home country of Ghana, I have become interested in how the clinical practica of students are organized at the Faculty of Nursing, University of Alberta. Clinical teaching is an area of nursing education in Ghana in which many changes are needed. As in many countries, concerns about the clinical inadequacy of new graduate nurses in Ghana have been raised.

Preceptorship, attaching a student to an experienced registered nurse who is working in a specific setting as a staff nurse, is a common strategy for senior practica in Canada (Chickerella & Lutz, 1981; Limon, Spenser & Waters, 1981). The practice in Ghana is to attach the student to a unit without naming a specific nurse as preceptor. Thus, while the function of the preceptorship exists, the roles have not been defined or recognized and accountability for student learning is diffused among all staff. Nursing programs in Canada are making use of preceptorship in clinical teaching to bridge the

practice-theory gap and to assist new graduates to become accustomed to the professional role (Ferguson, 1994; Ouellet, 1993). Myrick (1988) asserts that "in Canada and in the United States particularly, more and more faculty in university and diploma schools of nursing are resorting to the use of preceptorship for clinical teaching of their students" (p. 136). Studies have confirmed the positive outcomes of preceptorship (Hsieh & Knowles, 1990; Scheetz, 1989). In a study by Stevenson, Doorley, Moddeman and Benson-Landau (1995), there is a suggestion that preceptorship improves patient care because the preceptors increase their knowledge as they precept students. While positive outcomes of preceptorship have been identified, few studies have been done to ascertain the role of the preceptor. Nonetheless, the role of the preceptor has been said to include orientation of students to the work environment and imparting of clinical skills and knowledge to students (Fowler, 1996; Hayes, 1994).

This research project was devised to investigate and understand the roles of preceptors from the perspectives of: (1) preceptors; (2) faculty; and (3) students. How preceptorship is working at one university in Canada was explored. Reflection on the findings, in conjunction with a review of the literature critiquing the transfer of knowledge from North to South countries, has led to reflection on the applicability of preceptorship as a strategy for the clinical education of student nurses in the Ghanaian context. These reflections are shared in the final chapter of the thesis. Before presenting how I studied preceptorship in Canada, an introduction to the situation in Ghana will be given.

The Ghanaian Context

In Ghana, two main periods of clinical nursing training can be identified since the commencement of professional nursing training in 1945 (Boahene, 1985). Initially, there was an apprenticeship system. Students were used to provide service in the hospital and were expected to learn on the job (Akiwumi, 1988; Rose, 1987). In 1968, at the request of the Ministry of Health, the World Health Organization sent a team of consultants to develop a new curriculum for nursing schools in the country (Boahene, 1985). In 1970, a new program called the comprehensive nursing course began. Students in this program had full student status and were not under contract to provide nursing care during the course of their education. Faculty members were expected to assume responsibility as clinical instructors. However, the student-instructor clinical ratio was usually about 1:20 but could be higher. This was not conducive to an effective teaching-learning experience in nursing education. Osei-Boateng (1992) stated, "due to staff shortages students are often working in service units without supervision because of inability of the few nurse educators available to accompany them on rounds" (p. 176). Administrators complained that the nurses trained in the new program lacked clinical competence and were incapable of assuming responsible patient care. Hence, new graduates from schools of nursing lacked clinical expertise.

The Ministry of Health, in response to the criticism, introduced a one year internship program in 1992 to upgrade the clinical skills of new graduates from the comprehensive nursing program. The one year rotation was scheduled as follows:

(i) 20 weeks in the various health units within the medical /surgical nursing specialty area.

(ii) 10 weeks in the various units within the obstetric nursing specialty area.

(iii) 10 weeks in the various units within the psychiatric nursing specialty area.

(iv) 10 weeks in the various units of the public health nursing specialty area.

The one year internship was to ensure that the nurse acquired enough proficiency in the duties to enable her function well in any of the nursing specialty areas mentioned before going on for any post basic course. Supervision of the nurses during the internship period was shared among professional staff nurses. Because these nurse interns were accountable neither to the educational institution nor to the health care institution, many nurse interns took advantage of the situation and skipped duty, particularly if it was a clinical area of little interest to the specific nurse intern.

In 1993 the Ministry of Health, with assistance from the Department of Education at the University of Cape Coast in Ghana, revised the comprehensive nursing program. A new competency-based curriculum was developed. Currently, the new competency-based program is being tested in all basic schools of nursing in the country. Nevertheless, nursing education is greatly influenced by the general educational structure of the country, which of late has undergone rigorous changes. This recent change in the structure of general education has placed basic nursing education at the tertiary level of education whereby two types of institutions will offer programs for nursing education in Ghana. The first type of institution is the Regional Colleges of Applied Arts, Science and Technology (RECAAST). This program of study will be directed towards the higher

State Registered Nurse's diploma qualification instead of the present State Registered Nurse's certificate qualification acquired at the hospital schools of nursing. The second institution will be the University, where the program of study will be directed toward a four year degree in nursing education. It is predicted that transferring all nursing education to institutions of higher education will enhance recruitment of qualified students into nursing. Enrollment in nursing programs could increase. Faculty, however, may find that faculty student ratios increase and opportunities to directly supervise individual students decline.

What are the potential implications of these changes for the nurse educator? The few nursing lecturers at the university and nursing tutors at the hospital schools of nursing in the country will be faced with the dilemma of how to produce increasing numbers of nurses competent to assume registered nurse responsibilities without supervision immediately after graduation. Perciful and Nester (1996) suggest that, with the current diminishing size in faculty and the associated mounting demand placed on the few people left, changes in nursing education are inevitable. It is within this knowledge of the inevitability of change and the need to devise new strategies to meet the need for nursing education to prepare clinically competent nursing graduates that this thesis has been conceptualized. Interest in preceptorship in Canada led to reflection on the appropriateness of the approach for nursing education in Ghana.

In the past, scholars and professionals educated in Northern institutions just uprooted ideas and methodologies from those institutions to their home countries in the Third World. The transfer of knowledge from the North and its applicability to the

South was seldom questioned. Northern knowledge was accepted as authentic and thus was adopted internationally (Lee, Adams & Cornbleth, 1988). In recent times, this blind transfer of knowledge and practices generated in the North to countries of the South has been critiqued. There is the recognition that knowledge develops within a context and cannot be assumed to be relevant in all situations. Thus this study of preceptorship in a senior student practicum in Canada has allowed me to increase my depth of knowledge about the practice and more realistically assess the appropriateness of this strategy for the clinical education of nurses in Ghana.

Purpose of the Study

This study was undertaken to explored how faculty , students and preceptors at a faculty of nursing in a Canadian university perceive the use of preceptorship in the fourth year practicum, a course in which the students spend an entire semester of 13 weeks (excluding 39 lecture hours) in a clinical setting. As a researcher, I wanted to find out what preceptors recognize as their roles and the factors that enhance or impede the performance of these roles. I was also interested in how these perceptions corresponded to those of faculty and students. The final chapter of the thesis concludes with a discussion about the implications of the findings of this research in a Canadian setting in relation to the applicability for nursing education in Ghana.

Definition of Preceptorship

Preceptorship is a one-on-one learning experience in the clinical setting whereby the student is paired with a staff nurse who guides the student (Peirce, 1991). Chickerella and Lutz (1981) define preceptorship as "an individualized teaching/learning method. Each student is assigned to a particular preceptor for the entire three month semester so he or she can experience day-to-day practice with a role model and resource person immediately available within the clinical setting" (p. 107). This kind of plan enables the student to have individual supervision which in effect enhances his or her clinical efficiency (Shamian & Inhaber, 1985).

The preceptorship model is not merely an alternative to the buddy model but rather an organized schedule in which a student is assisted by the preceptor to acquire advanced nursing skills. This idea is congruent with Goldenberg's definition (1987/88) which says, "Preceptorships are unique experiences in which learners are guided by preceptors in delivering higher level practice skills. Objectives and terminal behaviours are clearly defined; educational accountability is ensured; and sponsorship is encouraged" (p. 11). Preceptorship is seen as a model that would aid the application of nursing theory to practice (Kirkpatrick, Byrne, Martin & Roth, 1991). Fowler (1996), in support of preceptorship, suggests that, "Nursing has moved away from task orientated care approach, to one where the patient's needs are cared for in a more individualized and holistic way. This has reinforced the idea of nurses becoming practitioners in their own right...Supervision will assist the process of socialization of staff into the values and beliefs, as well as clinical knowledge of the profession" (p. 472-473).

Research Questions

Perspective, according to Field (1983), "is a combination of beliefs and behaviours composed of: (1) a definition of various situations, (2) actions and (3) criteria of judgment" (p. 4). It was an interest in the perspectives of faculty, preceptors, and students from which the following research questions for the study were developed:

1. What is the preceptor role in working with students in a final year practicum in medical surgical nursing?
2. What facilitates the success of a preceptorship experience?
3. What inhibits the success of a preceptorship experience?

These questions were explored using a descriptive qualitative research approach.

Organization of the thesis

The literature review of research related to the use, effectiveness, benefits and issues of preceptorship in nursing education is summarized in chapter two. This is followed by an overview of the research process carried out for this study in chapter three. In chapter four, preceptor, student and faculty descriptions of the roles of the preceptor and how these relate to the nursing literature are outlined. In chapter five, factors that influence the effectiveness of preceptorship and other issues about preceptorship raised by preceptors, students and faculty are presented and discussed. Connections to the findings presented in chapter four are made. A general critique on transfer of knowledge from the North to the South introduces chapter six. This is followed by a critical evaluation of the applicability of the preceptorship model for nursing

education in the Ghanaian context.

CHAPTER TWO

The Use of Preceptors in the Clinical Education of Student Nurses

The preceptor concept is not new. As far back as the 15th century, the word preceptor was used in England to refer to an instructor or a tutor (Peirce, 1991). However, its inception into nursing is new. Increasing the use of preceptorship in nursing education is related to increased budget constraints requiring teaching and orientation methods that are cost-effective. Cost-effectiveness is viewed in terms of students, faculty, and staff time as well as the need to reduce reality shock to ensure clinical competence when students are initially employed after graduation. In this chapter, the literature relating to preceptorship in nursing is reviewed.

Why Preceptorship is an Attractive Option in Nursing Education

From a survey of nursing education programs, it is evident that preceptorship exists in all geographical regions of the United States (Lewis, 1990; Myrick, 1988; Peirce, 1991; Spears, 1986). Nursing service personnel contend that some nursing faculty lack clinical expertise, which cripples them as good role models in the clinical setting. Ferguson (1994) asserts that "nurse educators value preceptorial clinical experience as an effective means of assisting students to develop their clinical skills through exposure to expertise of practising nurses" (p. 6). Faculty appreciate registered nurses as having expertise in

clinical decision making and critical thinking abilities (Melander & Roberts, 1994). Registered nurses with clinical competence, who function as preceptors, serve as good role models for students (Andrusyszyn & Maltby, 1993; Burke, 1994; del Bueno, 1995; Porter, 1994; Spears, 1986) .

In addition, with decreasing resources, faculty size is currently diminishing with associated mounting work load of the remaining faculty. This has led to the need for a change in how nursing education is organized (Perciful & Nester, 1996). The preceptorship model, which introduces students to the real world of nursing while they are still protected as students, permits faculty to supervise a greater number of students and also have some time for other academic activities (Spears, 1986).

The Role of the Preceptor

The role of the clinical preceptor has been identified as orientation of students to the work environment, socializing students to the unit, supporting students as they learn in the clinical setting , teaching (especially with regard to the routine work of the clinical setting), and evaluating the clinical competence of students (Fowler, 1996; Myrick & Barret, 1994). Preceptorship has multipurpose functions which include assisting the student to make a transition from the student's role to that of a worker, providing an opportunity for the preceptor to grow professionally, bridging the gap between nursing education and nursing service, enhancing recruitment and retention of staff, and ensuring better patient care (Baird, Bopp, Kruckenberg Schofer, Langenberg & Matheis-Kraft,

1994; Hitchings, 1989; Limon, Spencer, & Walters, 1981). Overall, preceptorship appears to be a useful strategy for nursing students, as has been confirmed by students' formal written positive assessment (Chickerella & Lutz, 1981; Limon, Spencer & Waters, 1981; Ouellet, 1993).

Research on preceptorship has focused on implementation of the preceptorship model, programs, preparation of preceptors, benefits of preceptorship and rewards for preceptors. In their study of the role played by preceptors, Young, Theriault and Collins (1989) defined the role as a "set of shared expectations focused upon a particular position" (p.127). They found the role of the preceptor to be that of a nurse-teacher and a socializer.

Stevenson, Doorley, Moddeman and Benson-Landau (1995), in their study on perceptions of nurse preceptors regarding the preceptor role, observed that several preceptors mentioned being a role model. The preceptors attested that being aware of their roles as role models affected their behaviour and attitude in a positive direction. In feeling that they represented the agency and the profession, they were motivated to exhibit good clinical behaviours at all times.

It was realised that nurses who functioned as preceptors experienced a major role change. To assist with adjustment to the role change that the preceptors experienced while assisting others to acquire new roles, preceptors have been prepared by receiving a workshop on change theory (Young et al, 1989). O'Mara and Welton (1995), in a study on rewarding staff nurse preceptors, proposed that the teaching role of the preceptor must be strengthened by faculty support.

Effectiveness of the Preceptorship Model

Scheetz (1989) investigated the effect of nursing student preceptorship programs on the development of clinical competence. It was found that students who were engaged in the summer preceptorship program were more clinically competent than their counterparts who had worked as nursing assistants without a formal preceptorship arrangement. Clayton, Broome and Ellis (1989), in findings from a quasi-experimental study, indicated a higher score by the group of preceptored students on socialization as baccalaureate graduate nurses into roles of professional nurses. A similar study undertaken by Jairath, Costello, Wallace and Rudy (1991), to determine the effect of a preceptorship program upon diploma nursing students' (N=22) performance of the professional role using Schwirian's Six Dimensional Scale, yielded significantly greater improvements in those in the preceptorship program.

Myrick (1988) did a pilot study in which student nurses in the fourth year of the basic baccalaureate program worked clinically with preceptors for three weeks. Baccalaureate students who were not preceptored were found to perform better in planning and evaluation than those students who were preceptored. Preceptored students, however, had better positive self-perception. Myrick suggests that, until a staff nurse is taken through a carefully planned orientation program with emphasis on methods of performance appraisal, the staff nurse is not competent to assume the role of preceptor. Research on the value of preceptored clinical experience has led to differing conclusions. Myrick (1988) suggested that there are no differences in the performance of preceptored and non-preceptored students, Shamian and Lemieux (1984) found that the benefits of

preceptor teaching only emerge after a three-month interval. Goldenberg and Iwasiw (1993) recommend further research is needed about the issue.

Benefits of Preceptorship

The role of preceptor provides an opportunity for the preceptor to learn from the student. It was observed that, in a group of nurses who functioned as preceptors for three years, all except one wanted to continue with the experience (Chickerella & Lutz, 1981). A study of the perceptions of preceptors about the preceptorial experience indicated a great satisfaction in having contributed to the students' professional growth (Dibert & Goldengerg, 1995; Stevenson, Doorley, Moddeman & Benson-Landau, 1995). In the Dibert and Goldenberg study, preceptors stated that they undertook to precept because of the opportunity to help new staff nurses and student nurses settle into the unit, to impart knowledge, to help others improve their clinical skills, to upgrade their own professional knowledge and skills, and to have some intrinsic satisfaction in having contributed to the professional growth of others. Likewise, in a study by Stevenson et al (1995), several preceptors said that being a preceptor made them adhere to policy and procedures more carefully and thus enhanced better patient care. Rittman (1992), in her interpretive approach to studying preceptor development, also discovered the richness and complexity of precepting. Another commonly recognized benefit is the opportunity for professional growth (Chickerella & Lutz, 1981; Limon et al., 1981), particularly for senior nurses to renew their feeling of professionalism (Shamian & Inhaber, 1985).

Another study, conducted to determine if the preceptor orientation program

effectively met the perceived needs of the preceptors, showed a clear indication that preceptors perceived that they were adequately prepared for the preceptor role (Westra & Graziano, 1992). However, it has been recommended that preceptors, after going through an initial formal preceptor training course, should have periodic refresher courses (Stevenson et al, 1995).

Issues Related to the Implementation of a Preceptorship Model

The advantages of preceptorship are explicitly apparent. However, some issues such as criteria for the selection of preceptors, adequate preparation of preceptors, the development of positive relationships between preceptors and preceptees, and proper remuneration of preceptors have been acknowledged (del Bueno, 1995; Ferguson, 1994; Myrick & Barrett, 1992; Myrick, & Barrett, 1994; Stevenson et al, 1995). del Bueno (1995) evaluated preceptor competence and cost in an active care hospital. In the study, 27 participants were examined on a competency-based preceptor assessment system developed purposely for acute care hospitals. The institution in the study had already implemented a clinical assessment system called the Performance Based Development System. The assessment was based on critical thinking, interpersonal skills, and technical skills. It was discovered that all participants responded to the Problem Management series inaccurately, thus suggesting the need for preparation of preceptors.

Myrick and Barrett (1992), in their study on selection criteria for preceptors in Canadian basic baccalaureate schools of nursing, discovered that preceptors are utilized in 70% of Canadian university schools of nursing and that only 30% used specific criteria for

preceptor selection. Myrick and Barrett recommended the development of a tool for the performance appraisal of clinical preceptors. Yonge, Krahn and Trojan (1994) studied the perceptions of preceptors regarding preceptorship in nursing undergraduate education programs. They found that 95% of preceptors were diploma prepared. The preceptors rated themselves as proficient in nursing skills; however, most of them practised without using a nursing framework as a guide to their practice.

Thorell-Ekstrand, Bjőrvell & Blanchard-Caesar (1993), after studying preceptorship in clinical nursing in Sweden, found that clinical teaching may be improved if preceptors are selected according to certain criteria. Konkel, Soares and Russler (1994) discussed how preceptors were prepared to assume a facilitative role with students. They stated that the nursing education department at Valley Children's Hospital in Fresno, California has designed what they consider to be an effective preceptorship program. They developed a collaborative program with six elements:1) resource development; 2) central placement procedure; 3) preceptor preparation; 4) agency rotation; 5) evaluation; and, 6) university advocacy forming the collaborative framework.

In their attempt to develop preceptors, Rittman and Sella (1995) adopted a storytelling approach. The nurses were asked to write three narratives: (1) about an experience when they were a student that they will never forget; (2) about an experience they had with a patient; and, (3) about an experience they will never forget because it taught something about precepting. The writing of the narratives was assumed to promote reflective thinking about practice. Meng and Conti (1995) devised a program for the professional development of preceptors which accentuated feedback and evaluation and

initiated critical thinking as content.

In respect to remuneration of preceptors, Lewis (1990) attested that "beyond the gratitude of the students and faculty members, there was no monetary or promotional gain,..." (p. 19). O'Mara and Welton (1995) investigated rewarding staff nurse preceptors. In their recommendations, they said that monetary compensation and dinners are not possible in this era of prevailing high cost in health care. A continuing education program provided by faculty for preceptors, faculty assistance with research endeavours and faculty consultation with clinical projects were suggested as alternative strategies by which preceptor commitment to their role could be rewarded. Another study on the preceptor experience suggested that preceptors desired formal recognition of their role. Inclusion of preceptor responsibility in performance appraisal, professional recognition in health care publications and additional income were mentioned. They wanted to be involved in discussion of matters pertaining to preceptorship and in continuously updating their knowledge and skills (Stevenson, Doorley, Moddeman & Benson-Landau, 1995). In their recommendations, Stevenson et al (1995) proposed that, "Mechanisms that positively reward preceptors must be formalised" (p. 165). Dibert and Goldenberg (1995), in a study on preceptors' perceptions of benefits, rewards, supports and commitment, found that preceptors might be more devoted to the preceptor role if they were given support, rewards and benefits. They recommended that further research be done to ascertain the type of reward and benefit that would be meaningful to sustain an effective preceptor role.

Another problem of preceptorship identified in the research literature is that of trying to fulfil two roles simultaneously (instructor and practitioner) (Burke, 1994; Hayes,

1994; Yonge et al, 1994). Hayes identified that, "A preceptorship adds extra time and energy to an already busy schedule and agency responsibility. Being with a student all day is an intense, sometimes stressful experience. Students ask endless questions,...The student makes demands on the preceptor who must be on "good behaviour" at all times... act between client-student-faculty-agency expectations" (p.63). As well, precepting a student whose level of performance is just average or below average (Rittman & Osburn, 1995; Yonge et al, 1994) or where there are personality conflicts between the preceptors and the students which hamper working relationships (Lewis, 1990) is difficult.

Hsieh and Knowles (1990), in a study on the development of the preceptorship relationship addressed three questions: 1) What are the specific elements essential to the development of the preceptor relationship? 2) What is the role of the instructor in facilitating the development of the preceptorship relationship? and 3) What are the variables affecting the developing preceptorship relationship? From the feedback provided by the preceptors (N=12), students (N=12) and faculty (N=12) about what was crucial to the development of the preceptorship relationship, the following seven factors were identified. These factors were: trust; clearly defined expectations; a support system; honest communication; mutual respect and acceptance; encouragement; and mutual sharing of self and experience. As a result of studies such as these, measures have been taken to help the preceptor-preceptee relationship. In Royal Cornwall Hospital in England, a study session has been organized for both preceptors and preceptees. The study package covers areas like clinical supervision, staff appraisal, professional portfolios, discharge planning, applying research in practice, ethical dilemmas and national

service issues. This preceptorship support program is evaluated at the end of each preceptorship session (Jackson, 1996).

Reflections on the Preceptorship Literature

Despite the problems with preceptorship, the preceptorship model continues to gain popularity as no other adequate solution has been found to bridge the gap between the transition from student status to that of a professional. A review of the literature on preceptorship has revealed research on many different aspects of the concept; however, little study has been done on the role of preceptors. While Hsieh and Knowles (1990) and Westra and Graziano (1992) addressed the perceived needs of preceptors before and after the preceptor experience, no qualitative research literature on the role of the preceptor from the perspectives of preceptors, faculty and students has been found. Thus a qualitative study, as outlined in the next chapter, was conducted.

No research examining cultural differences in a preceptor-student relationships has been done. Given that both the United State and Canada are pluralistic societies, such investigation could be useful.

CHAPTER THREE

The Research Process

In this study, a qualitative exploratory research design was adopted. Qualitative research methods enhance the exploration of realities from an emic point of view (Morse & Field, 1995). An exploratory descriptive design, utilizing data collection methods commonly associated with ethnographic studies, was employed. While this was not an ethnography, data collection methods congruent with an ethnographic approach were utilised. "Ethnography is a systematic attempt to discover the knowledge a group of people have, and are using, to organize their behaviour" (Field, 1983; p. 3). Ethnographers learn from asking people rather than studying them (Morse & Field, 1995). In the past, ethnography was a method limited to anthropological studies of people, especially in the colonial context, but now the method has been employed in the realms of nursing, social sciences, literature, and even policy making (Muecke, 1994; Field, 1983). Ethnography has been assimilated into health care research by nurse-anthropologists such as Aamodt, Leininger, and Ragucci (Morse & Field, 1995). Leininger and Brink have called for nurses to use qualitative methods in nursing; particularly, ethnographic methods to explore issues of interest to nursing (Boyle,1994). "Ethnography, always informed by the concept of culture, is a generalized approach to developing concepts and understanding human behaviours from the insider's point of view" (Morse & Field, 1995; p. 23-26). This approach has permitted me to explore and describe the preceptor's role

from the "emic" perspective of the preceptors as well as the perspectives of faculty and students.

Morse (1994) asserted that, in qualitative research, theory development, description and operationalization are the aftermaths. Data collection in ethnography is by unstructured interviews, observation and field notes (Morse & Field, 1995; Muecke, 1994; Field, 1983; Ragucci, 1972). Interviews were the primary data collection method in this research. As preparation for the research, but separate from the study, I gained experience in observing student/instructor and student/preceptor interactions in the clinical setting.

Research Design

Sampling and Selection

Sandelowski (1995) has affirmed that "the various kinds of purposive sampling used in qualitative research lie primarily in the quality of information obtained per sampling unit, as opposed to their number per se" (p. 179). In qualitative research, a good sample size does not depend on the number as much as it does on who has the information that is needed. "An adequate sample size in qualitative research is one that permits - by virtue of not being too large - in-depth case-oriented analysis that is the hallmark of all qualitative inquiry" (Sandelowski, 1995, p. 183). Muecke (1994) said that "The number of key informants is limited; they are usually persons with store of knowledge and experience relative to the problem or phenomenon of study" (p. 199). In qualitative research, sample size cannot be confirmed in advance. It depends on the

"appropriateness" and "adequacy" of the data obtained (Mores & Field, 1995; Morse, 1987). Sampling continues until data are saturated (Morse, 1991). What this means is that when no new information is being revealed in the interviews, saturation of data has been achieved and an adequate sample size has been selected.

The study was sited at a faculty of nursing in a Canadian university. The preceptorship model for the senior student nurse practicum has been in practice at this university program for more than a decade. Interviews were conducted with five students, five preceptors and four faculty members involved in fourth year student nurse clinical experiences in medical surgical nursing. Potential faculty participants were identified by the thesis supervisor. Only six faculty members have had experience teaching preceptored courses in medical/surgical nursing in the fourth year of the current curriculum. A covering letter describing the project (Appendix A) was sent to these faculty members. All faculty who participated in the study have full time positions (three tenure track and one on contract).

I sought and secured the cooperation of the faculty who were currently teaching the senior practicum in recruiting student and preceptor participants for the study. The faculty members informed the students about the project and gave the information letter (Appendix B) to those students who expressed interest in participating in the study. The same faculty members informed preceptors about the study and made the initial connection, by giving out a letter with the description of the project (Appendix B) to the interested preceptors. They then furnished me with the contact addresses of both interested students and preceptors. Preceptors who were precepting for the first time were

excluded from the study. I contacted the preceptors and students by telephoning them. I made efforts to establish rapport, a relationship of mutual trust and respect, with interested students and preceptors as "establishing credibility and trust are the criteria if the researcher is to obtain relevant and adequate data" (Morse & Field, 1995, p.133). Hence, a purposeful sampling method was adopted in recruiting participants for the study.

Stress on preceptors in the clinical areas had increased under current health care reform and it was envisaged that gaining interested preceptor participants might be difficult. That was not the case. Preceptors who were approached showed great interest in participating in the study. Most preceptors were articulate and provided very rich data, especially during the first interview.

Demographic data were collected on the preceptors.They ranged in age from 34 to 44 years. Three of them were diploma prepared and two were BScN prepared. The BScN graduates had all experienced preceptorship in their senior nursing practicum. All of the preceptors were working as full time nurses, had more than ten years working experience and had preceptored more than once. Of the 14 people interviewed for the study, 12 were Caucasian. One student and one preceptor were of Asian origin. All persons interviewed were female.

Data Collection

Interviews occurred over a six-month period. Interviews in qualitative research provide the arena for the interchange of both verbal and nonverbal communication

(Hutchinson & Wilson, 1994). An interview is a process of exploration (Field & Morse, 1985) and, according to Hutchinson and Wilson (1994), interview questions in qualitative research are framed to invoke information that will assist the researcher in finding domains or categories of meaning from which themes may be established.

Tape-recorded face-to-face interviews were done using semi-structured, open-ended questions. While it was planned that each participant would be interviewed twice and, if there was a point to clarify, then a third interview would be done over the telephone, it was found that a single interview was adequate in most cases. Some of the participants expressed the view that they had nothing more to say after the first interview. For such participants, the researcher sought permission to contact them by telephone if any clarification was desired. Those participants who felt they still had more information to give were interviewed again. Any time that there was a need to clarify a point from a participant, an interview was done over the telephone. Of the 14 participants, only 4 were interviewed twice. All participants were sent copies of the transcripts of the interviews with them and given the opportunity to add or clarify information and to sign that the transcription accurately reflected their views. The transcripts were returned to me with no major changes made by the participants.

The interviewing process followed an inductive approach, moving from a broad generalised area to more specific focus with the interview questions becoming more structured. The transcripts of the first two interviews were shared with my thesis supervisor prior to subsequent interviews. The initial interviews lasted mainly between 60 to 75 minutes and the second interviews from 30 to 45 minutes. The second interviews

built upon the participants' previous stories to explore areas of special interest and to discover areas of emerging constructs of commonality and difference. May (1994) proposed that in qualitative research the process involves " Moving from intuition to insight, from an interesting but a quirk question to an important revelation...." (p. 20). Guiding questions for the interviews may be found in Appendix C.

Demographic data were collected on preceptors (Appendix D). This information was useful in describing who the participants were with regard to their professional nursing experience as already has been reported. I kept a personal diary which served as a "dialogue with self" (Ragucci, 1972). This helped me to recollect personal thoughts, emotions and insights during sampling, data collecting and analyzing stages. A brief description of all participants was included in the field notes which were being kept as a part of the diary. Thoughts relating to the relevance of interview data to the Ghanaian context were written in the diary as such insights occurred. Thus reflecting on the meaning for nursing education in Ghana began with the first interview.

Data Analysis

Initially, no data were discarded or ignored (Morse, 1995). Analysis in qualitative study starts with the first question posed to the respondent, because the response from the respondent is analyzed before posing further questions (Henderson, 1995). Henderson contended that "the true start of the analytical process in qualitative research is at the outset of the 12 steps of a research project. Plans for analysis begin when the study purpose is crafted. When the study objectives are outlined, the seeds of analysis are

planted" (p. 464). Therefore, analysis began with the first interview and was an ongoing process as data were being collected. The interviews were coded by assigning numbers to the participants to ensure confidentiality and to avoid intermixing of data. The diary records and memos were reflected upon, corrected, extended, edited, typed, and labelled soon after each interview (Huberman & Miles, 1994). The audiotaped interviews were transcribed verbatim. The transcripts were double-spaced with a blank space between speakers. Immediate analysis with precise coding and labelling of the data eliminated any pile up and confusion of data. Three copies of the transcripts were made and the original copy kept separate from the working copies (Field & Morse, 1985). A definite filing system for hard copies of transcripts, audiotapes, and memos was maintained because a good storage and retrieval process is crucial for keeping track of data (Huberman & Miles, 1994).

Because I conducted the interviews and transcribed the audio-tapes myself, I was immersed in the data. I reviewed the data repeatedly in order to be familiar with it and thus to identify common concepts, themes, incongruencies and common terms within the interview data (Ragucci, 1972). The data were examined and coded by categorizing, comparing and conceptualizing patterns that appeared (Rodgers & Cowles, 1993). Negative cases, which in quantitative studies are termed as "outliers", emerged at this point of the analysis and were handled with great interest and care because in qualitative studies negative cases are crucial to the understanding of qualitative data. Morse (1995) stated " it is often the infrequent gem that puts other data into perspective" (p. 148). Negative cases are of significance because they illuminate additional causal properties

which influence the phenomenon under study (Denzin, 1978; cited in Field & Morse, 1985). Computer application may be used at this point to connect codes, categorize data and track data exploration (Taft, 1993) but a decision was made to use the "cut and paste" method for organizing the data in this research. An adequate record of all analyses and their outcomes was kept, no matter how irrelevant they seemed to be at the time. These analytical notes formed part of the audit trail which would help in retracing the path of the data analysis, should there be a need to demonstrate the rigor of the analysis (Rodgers & Cowles, 1993). The data were synthesized by linking the concepts and themes identified from the transcripts to give a thick description of the findings (Morse, 1994).

In order to ensure a rigorous analysis, the thesis supervisor reviewed some of the data to identify any source of bias, as well as any inconsistencies in the interpretation of the data (Robertson & Boyle, 1984). Data from faculty, students and preceptors were compared to ascertain areas of agreement and difference.

Research Standards

Sandelowski (1986) addressed the issues of reliability and validity in qualitative research rigor and outlined a framework for ensuring rigor in qualitative research. The standards for appraisal of rigor or trustworthiness include credibility, auditability, and confirmability. These were employed to assess this research.

Credibility or truth value is the faithful presentation or description of a human experience so that the people having that experience recognize it as their own by the way

it is presented. This was achieved by presenting findings accurately in order for the participants to immediately recognize the statements as their own due to the correct description and interpretation revealed in the research findings.

The auditability of the study implies that another researcher could follow the "decision trail" used by the initial researcher to arrive at the same or comparable conclusions (LeCompte & Goetz, 1982). This consistency in qualitative research is the reliability of the research (Sandelowski, 1986). Reliability implies another researcher repeating the study would arrive at similar findings. A clear decision trail provided by the original researcher allows for checks on reliability. Meticulous documentation was used to yield an excellent audit trail.

Confirmability applies to freedom from bias or open-mindedness displayed in the procedures and final findings of the study. Confirmability is established when auditability and applicability are possible. In this study, a clearly documented audit trail and participants' verification of findings were the criteria for confirmability.

Morse and Field (1995) established that the validity and reliability in qualitative research depend on the sample. In order to obtain rich data, a purposeful sampling should be done to enlist participants who have good knowledge about the needs of the study. To ensure that the data were "rich", informants from various areas were selected. Hence, the study should meet the criteria of " **adequacy**" (Morse & Field, 1995, p. 223). In this research, the help of credible faculty professors working with preceptors was sought to identify preceptors who were suitable for the study so that the criteria for adequacy could be be met. Interviewing continued with the three research cohorts until data were

saturated. The second point established by Morse and Field (1995) is consistency in interviewing which they think enhances the validity of a qualitative study. As outlined earlier, after each interview, the transcribed interviews were reviewed by the participants to ascertain accuracy and corrections were made where necessary. Another criterion for establishing validity and reliability in this study was fitness. What this means is that data collection and analysis of the data were grounded on the research questions and compared with reports of studies on preceptorship found in the literature (Ogilvie, 1993).

Ethical Considerations

Consent Procedures and Forms

The procedures for accessing participants have been discussed in the section of the proposal on sampling and selection. Each participant signed two copies of an informed consent form (Appendix E). One was kept by the participant and I kept the second copy in a locked cabinet. Participants were made aware of their right to withdraw from the study at any time without hesitation, the right to ask for any clarification concerning the research, and the right to be informed of any potential harm or gain in connection with the study (Ford & Reutter, 1990). A copy of the summary of the results will be sent to those participants who wish to see the findings of the study.

Confidentiality

The identity of participants is known only by me and, in the case of faculty participation, by my thesis supervisor. Strict measures have been taken to maintain confidentiality. Recording of identifying information on the demographic data sheet was avoided. Code numbers were assigned to each participant and the list which connects participants to the data was kept separately from the data. Interview information about them and field note records were treated anonymously (Morse, 1994). Research findings and exemplars reported in the thesis (or in any subsequent papers for publication and conferences) do not identify participants by name. The raw data are available only to the researcher and the thesis committee members, who hold all information as confidential. The consent forms and background information have been locked in a cabinet for the duration of the study. The transcripts, audiotapes and field notes were kept in a separate locked cabinet, but readily accessible to the researcher during all the stages of the study.

Disposing of Data

After the study, the background information and the list connecting participants to the data will be destroyed. The rest of the data, including the audio-tapes, will be retained for seven years, after which they will be destroyed in accordance with the specifications outlined by the University (University of Alberta, 1991).

Risks versus Benefits

There were no perceived risks nor direct benefits to the participants who decided to partake in the study. Although there were no direct benefits, the idea of participating in a study of this nature could enhance the perception of the preceptor's role. Sharing of the results may provide a concrete step and a framework from which to proceed with their role in the future.

The Faculty of Graduate Studies where the study was done requires that ethical clearance be obtained for conducting research involving human beings. Clearance for the study was obtained from the Faculty of Nursing at the University. A letter from the Dean giving permission to interview students was obtained. Permission to access preceptors employed as staff nurses by the Capital Health Authority was obtained. Copies of letters of permission may be found in appendices F,G and H.

Limitations

There is no method without inherent weakness (Cohen, Knafl & Dzurec 1993). Research standards and criteria set for analysis were met. An anticipated problem was that of language and interpretation difficulties related to cultural differences between me and the informants. Differences in interpretation, however, could be viewed as an asset for discussion of such differences may lead to new insights on the meaning of the data. In reality, few such differences emerged during the research process.

Reflections on the Research Process

I was skeptical about conducting a study here because of cultural differences. I was convinced that nobody would be interested in participating in my study. I was wrong. It was all a great thrill when my supervisor paved the way to the faculty members who in turn paved the way to the students and the preceptors. The first interview was taken from a faculty member and the serene atmosphere created in her office set the ball rolling for me. After that first interview, what I wanted to do became very clear to me. Following the process step by step as outlined, I developed a clear insight for the study. I was invited by both students and preceptors to their homes to do the interviews. Every interview was like having a chat, in a friendly environment, listening to what the role of the preceptor is and other related concepts. The most fascinating part was sitting alone listening to the tapes and typing. Transcribing the interviews made me very familiar with the data. The individual participants cleared any doubts and made the study a reality.

CHAPTER FOUR

Roles of the Preceptor as Viewed by Faculty, Students and Preceptors

As data were collected, it became evident that faculty, students and preceptors have very similar conceptualizations of the preceptor role. Seven roles were identified: teaching; orientating students; inspiring, supporting and building students' confidence; evaluating student performance; socialization of students; role modelling professional nursing practice; and providing an alliance for future employment. In the text, exemplars from the participants are presented under code names where F1 to F4 refer to faculty, S1 to S5 to students and P1 to P5 to preceptors.

The statement below describes the role characteristics identified by a faculty member in one of the interviews:

> ....Traditionally, the role of the preceptor is someone who took a student. Who is used to being with a teacher. Who is dedicated just to teaching you know, a group of students. And who is sort of going to make this transition into being an independent nurse on their own. So traditionally that I have seen preceptors more in the last part of the program just before they graduate, kind of make sure that there is someone there but in a way before the student becomes more independent or allowing them to be independent but still they have a nurse to work with, contact, to work with to be inspired by, to be motivated by and to be supported by and to learn from as is very clinically related.... Preceptorship is like bridging, a bridging step transition to a graduate nurse. (F1)

Teaching of Students

Faculty members recognized the preceptors' efforts in helping students learn clinical knowledge, skills, and judgment. Preceptors teach students hands-on skills as well as clinical knowledge and judgment. Review of the literature confirms that teaching, especially the routine clinical work, is one of the major roles of the preceptor (Fowler, 1996). A faculty member said:

> They are not just giving students tasks to do but they are also giving the responsibility of complex nursing care that looks at larger issues just than saying okay, it is time to do vitals so go and do vitals, bed bath or something like that. They actually let students take on the responsibility of looking at the whole picture and planning nursing care and allowing the student the flexibility to do it in a way they will do it provided they are providing safe care. (F4)

Another one declared:

> Even if a student is a good student and comes and works hard, they still have to teach her/him. They have to take time off their schedule to teach students.... They are going to take extra time not only to teach the students but talk to the teacher when I show up there. (F1)

A third faculty member concluded that:

> Some of them even send students home to do little assignments and there is no way that faculty can give that one-on-one guidance to each student on the ward. It is impossible to do that and faculty tend to teach things as it should be done but with preceptors I think they get a better idea of the real world. (F3)

Being cognizant of the teaching role of the preceptor, all faculty members in the study said that they gave guidelines to the preceptors in connection with their teaching role. Faculty must provide preceptors with adequate information on the entire program, course objectives, and the desired student outcomes. It is argued in much of the literature that most preceptors are not educationally prepared to teach students (Ferguson, 1996; Jackson, 1996). Ferguson (1996) contended that, "Nurses who agree to precept students must be supported in their educative role" (p. 73). It is, therefore,

the responsibility of the faculty to give that backing to preceptors.

The students were keen in describing their clinical learning experience with their preceptors. They affirmed that their preceptors assisted them in applying theory to practice, and that they learned new things from the preceptors and mastered hands-on skills as well as increasing their clinical knowledge. They were taught daily ward routines, how to interact with physicians and other health professionals, and how to transcribe physicians' orders. Time management and organization of patient care were important skills to acquire because getting to the end of the experience they took on the full load of patients as would normally be assigned to Registered Nurses. They were also given the chance to function as team leaders and give report on the whole unit. Their learning objectives were met and one student said:

> I think preceptorship is good, for preceptors have been working in the hospital for so long and they know their job well. Instructors have been teaching for long, they know their stuff but maybe some of the things they don't know, like daily routines. My preceptor taught me what nursing is in the clinical environment because there were a lot of skills that we were taught in the lab and she guided me how to do some of the stuff in the clinical setting. She kind of orientated me to the unit like, "This is in there and that is there". Like some of the stuff I knew but some stuff in the unit I have never seen before like how to use the bladder scanner and the catheter. She gave me the opportunities to do new things and finding new stuff for me to learn. She was good at that. I don't know how else student nurses can learn. I think we need preceptors. (S2)

Another student said:

> She is excellent! Usually, she will say, "You only learn by doing". When I am going to set IV line..."Oh my God! I don't know what I am going to get" and she will say"Let us struggle and think of things that you will dig out". So I will collect the things and I said, "I have this now. What am I going to do?" She will walk me through it about what I got to do so I feel comfortable with all the procedures now. She does let me sort of do it myself but she is always watching. So it is a matter of practice and I am glad that the preceptor has

given me the opportunity to practice. (S1)

> Even when she is doing procedures, she is a tremendous source of knowledge. She knew everything. It sounds like exaggeration but if I asked her, she knew it and it was fabulous because I really respect people who know what they are doing and for me, I kept saying, "I need to be like that, I need to be like that" to seek out the knowledge. (S5)

"The teaching role of the preceptor is not to be confused with that of the faculty teaching role" commented one of the preceptors. According to the preceptors, they guided the students with hands-on activities, facilitated and assisted the student in critical thinking, found out where there were gaps in knowledge and filled those gaps. They also taught students things that were unique to the units. They emphasized that it was important that instructors teach students the general things they need to know before sending them to the units. This would save preceptors a lot of time that they need for patient care. Preceptorship is a voluntary job and instructors should not expect preceptors to do their jobs for them. In the words of the preceptors:

> Oh well like, I explained before with the example of the diabetic, I don't think it is our responsibility to teach the ins and outs of different insulin and measurements. When you have Toronto Insulin and NK Insulin, rather than telling the student, you ask, "Which will you draw first and why?"....Then it may also be necessary to teach about the special conditions you might get on your unit and that the instructor might not even know.... I would expect that it is my job to be unit specific about ward routines, about what it is also in terms of teaching about the expectations of the unit. I think it is important when the student is first assigned to the unit to sit them down and say, "I have your clinical objectives here and on top of that you need to know that this unit expects you to arrive on time, to complete your assignment at the time allotted, to become a team player.... If you have any questions whatsoever, you alert me". That sort of teaching is very necessary because it gives the preceptor a little bit of control over the what is going to happen in this relationship. (P5)

> Well so I have been staying with her and giving her a lot of guidance and suggestions...I am still checking on her medications because she gets mixed up for sub-Q injections. She has been using IM needles and I caught her twice. And coming from different schools of nursing they have different levels of patient care that they can do. But once I found out what level they were and what they were able to do made it easier . I was able to show them what they needed to see and what they could do on their own. (P4)

> I have to kind of tell her, "You cannot really put all 15 minutes doing this because you have more patients and you are going to be behind. So you have to really itemize your work early in the morning" . So what I have suggested for her is, "Why don't you pour your medication before report time? That will give you 15 minutes earlier" because some of the students are kind of slow, not like us. As soon as you look you know what is going on and you know how to budget your time... (P1)

As teachers, preceptors introduce students to what registered nurses do and why they do things in certain ways (Hayes,1994). Ferguson (1994) concluded that "Preceptorship is not, and can never be, an abdication of faculty's responsibility for the education of students" (p. 80). Faculty must continuously be in touch with the student and the preceptor.

Inspiration and Support

The second role of the preceptor as perceived by faculty is that of inspiring and supporting students. They talked of preceptors identifying students' weak points and assisting students to get over them. It is also important for someone to promote nursing as a good profession in order to encourage students to desire to become nurses and to remain in nursing. The preceptor is one person who does this kind of promotion through her actions and communication with the students. A faculty member asserted:

> We do not run into problems with students being with preceptors or preceptors

> feeling uncomfortable identifying areas that might be weak and need some work....They impart to the students a bit about sense of hope and enthusiasm as to what they do as nurses. (F3)

Another faculty participant said:

> Preceptors help students to realise how good it feels for somebody to answer your questions. (F4)

Support is necessary to consolidate knowledge and skills acquired in the clinical setting (Jackson, 1996). Understanding and acceptance from the preceptor enhance the student's learning. Spouse (1996) contended that, "Now that nurses are educated in diploma or degree programmes where they spend the majority of their clinical experience as supernumerary members of the clinical team, an effective system of educational support is essential for their success as professional practitioners" (p. 32). Supportive relationships were fostered in an atmosphere where the students felt accepted.

The support role of the preceptor, according to students, included allowing opportunities for students to make mistakes while learning hands-on skills, correcting them but not condemning them and giving them autonomy in their practice but being close enough for them to call on for help when it was warranted. Positive feedback boosted students' confidence and encouraged them to practise. Also walking them through the process gradually without pushing them gave them time to build their self confidence. Friendly interactions from the preceptors initiated a sense of trust, warmth and interest (Spouse, 1996). Students made the following statements :

> My preceptor was not harsh and I was grateful I had her. She made my learning a lot easier and more comfortable for me. Second day, she assigned me my own

> patients and I did everything for the patients. She was not always looking at my back, criticising and making me nervous. She was very supportive and I could always approach her. She was not stern and that made it easy for me to ask her things. I felt comfortable with her and of course, if I feel comfortable, then I can ask questions. I was grateful that she was good. (S2)

> I told my preceptor, "I know it is hard on you to stand by and let me do something very slow and awkwardly but unless it is very critical, could you let me try first and watch me. But if I am going to do something wrong, of course, stop me. But just let me see if I am going to catch up my own mistakes before you do"... I said, "Thank you for not saying that because now, I can remember". But it takes a special kind of person to do that. Somebody who is not intent on proving that you don't know. And I don't know how many people there are like that. I do really appreciate that. (S1)

> She was really fantastic, she was a true mental support system for me and a real source of guidance. She challenged me and it was like.... everyday for a month and a half I have to report to one person and that was fabulous. It was really a terrific experience so she was really a source of advice, guidance, knowledge. Tremendous amount of knowledge. (S5)

Students appreciated preceptors who were aware of the students' feelings of incompetence and gave them room to practice on their own, tolerated their mistakes and gave them constructive criticism without condemning or threatening them. According to the preceptors, these were some of the strategies they employed in supporting students:

> If you have a student who is not confident... she walked in and said, "Oh my God! How am I going to do this?" you know. I said, "Take it a little bit at a time, take 1, take 2, take 3, keep at 3 patients for a while". And pretty soon she was bored with just 3 people. But I mean it was important to keep telling her that she was doing well. They know when they are doing well and they know when they are doing poorly but still, I like to pat them on the back. (P2)

> Like with the student I said, "You have been doing this really well. Why don't we try doing this?" And she was kind of skeptical, "Do you think I can?" and I say, "Well why not? I am around to help if you get stuck. I will be part of it but let us just try it". So she is like two nights later she said, "Ah, I did all that".

> So we go to coffee together. We go to lunch together. So we talk about these things. (P3)
>
> I have told her things and she just doesn't hear them and I will say, "I told you this and you said yes, and yet you are not following with me here" and she will say, "All I can figure out is this". .. It is possible that she could be intimidated because when we go for coffee she is relaxed and she can carry on conversation and she hears everything that you say. What I did was a road map. I basically gave her a time line and I was quite set about it so she does that and she is quick a little bit. Also she tries very hard like she comes in early. (P4)
>
> The other thing is you do feel a lot of responsibility. For me I think it is a good thing because I wanted to be responsible for making sure that my profession is remaining safe. And professionally, at the same time, I know that I hold that girl's career in my hand for that number of weeks and at the end of it... knowing how much this girl's future has been influenced by the word you put on paper so that will be the worse thing. (P5)

What was very impressive was the commitment that many preceptors had to nursing and the need they expressed to positively influence the practice of students as they enter the profession.

Evaluation of Student Clinical Competence

The evaluation role of the preceptor was acknowledged by faculty members as very crucial. Students often felt inadequate and incompetent because they had been away in the community in the third year of the nursing program and had almost forgotten many of the things that went on in the acute care setting. Therefore, feedback from the preceptor was critical to the students' feelings of self-confidence. It was important also to assess the student at the beginning of the term to know what areas of the student's learning were to be emphasised. Throughout the term, continuous evaluation was needed to tell if learning objectives were being met. At the termination

of the relationship, summative evaluation was important to decide whether the students were ready to step into the role of the graduate nurse. An instructor said:

> In the beginning it is a lot of work for the preceptor all because getting to know the student and what learning needs they have. Gradually they will be able to give some of their assignment to the student and by the end the student nurse will actually be working full time. So they should be working close to the role of a graduate nurse by the time they finish and not at the beginning. I mean working as a graduate nurse and that is what we are looking for. (F3)

> But I don't have preceptors mark any assignments. This is the most I ask them to do. There is a one page form that is easy. It takes one minute to write. How was the student? Good? How were the student's bedside skills? Good? How well was the student's attitude?... and I tell the preceptor whatever you are going to do or you are comfortable with. And occasionally I have students who phone me and say, "Can I get a copy of this?" and I say "No, if the preceptor didn't show it to you, no; and if the preceptor didn't give you a copy, no. This form was sent to me by your preceptor and I am sorry." Most of the time they are very good. (F1)

Evaluation is a very significant process in the learning and teaching alliance. Continuous evaluation by the preceptor weekly, at midterm and at the end of the course is needed. Grading, if required in the course being studied, can be problematic. Interviews with faculty indicated that they consider evaluation to be a very important teaching task and expected preceptors to do some evaluation on the students they preceptored. Ferguson (1996), in her study on preceptors' needs for faculty support, found that preceptors were not the final authority in the preceptored experience evaluation but that they did provide evaluation comments of students' activities during the relationship. Dibert and Goldenberg (1995) identified evaluation as one of the vital roles of the preceptor in the preceptorship relationship, but one to which very little or no attention has been given. They attested, "Evaluating preceptee performance is critical to the preceptor role, yet most preceptors have had little or no experience with this process" (p.1149).

Students attested that their preceptors assessed them on an on-going basis and finally at the end of the relationship. Initial evaluation assists the preceptor in identifying the student's needs, potentials and assets. The summative evaluation confirms to the faculty whether the student is ready or not to step into the role of a graduate nurse. The students usually handed over the evaluation forms to the preceptors. Some of the preceptors shared the on-going and the final evaluation with the students while others did not give much feedback to the students. One student felt that she had not been fairly treated on the issue of feedback. Other preceptors shared only the on-going evaluation with the students and mailed the final evaluation directly to the faculty. A student declared:

> She does say, "You did that well. All you have to do is to speed up a bit" I know I have to speed up but it is not easy to speed up when you are trying to think. And so she does some evaluation and I can tell that she is evaluating as we go along. (S2)

Another one stated:

> From my second preceptor I got to know I was doing better. She never said anything negative. She told me areas that I needed to fix so that was good because you need to know which areas you need to improve but I missed that aspect of it in the first half. In my first place, the evaluation I got wasn't very good but she didn't say anything to me when I was going through. Like she always has a smile or she was always pleasant... but the evaluation I got was not fair As far as what to evaluate, on our course outline there are some characteristics listed for evaluation...I don't think the first preceptor used them at all because there was no indication that I remember. I am a little bit confused as to how the preceptor is to evaluate us. Are we compared to a nurse in that unit or as individuals? I think the first preceptor evaluated me as to how I will be as a functioning member of that unit. (S4)

These were the comments of some of the students on the evaluation role of the

preceptor. Nevertheless, the preceptors saw evaluation as one of their main roles when working with students. Evaluation permeated throughout the relationship. At the initial contact with the student, it was necessary to evaluate the student on an individual basis to establish the student's strong and weak points. Evaluation then became a daily process to determine progress and also to identify where emphasis should be placed. Summative evaluation at the end of the period was considered extremely important. In many situations stepping into the staff nurse's role with confidence depended very much on what the preceptor stated in her/his final evaluation. A preceptor claimed:

> Basically, when my student came I evaluated her just to find out how far she has come at that point. How much stuff she has to learn. So I have to really assess how much knowledge she has in the area in which we are going to work together. We do sit down to look at her objectives and know where to work from. And from time to time we do a conference together and I say "What else do you need to learn?" (P1)

Another one alleged:

> You have to keep a mental note as well as keep jotting down as the time period goes. And if things don't go smoothly at that time I prefer to let them know at that time so that they can have the chance to improve. The faculty provides an evaluation form so that at the end of the experience the student is already aware that you have this evaluation form and they have seen it. It is important and I always make it a point usually on coffee breaks or lunch breaks especially by midway through the experience. Then I will know how they are doing and if there is anything that they need to polish up on. I am very aware that they are students so I do not expect them to be on top. They will pick up when they make a mistake and they are worse on themselves than I will be. So they need a lot of reinforcement on the things that they do right and only a little bit of focus on the things they do wrong because they are usually aware. My evaluation is not necessarily so much about procedures. A lot of the students become very procedure oriented, "Oh I haven't put in an NG tube and I haven't started an intravenous" things like that and I let them know early that it is not my expectation. That their evaluation is not in anyway influenced by the number of procedures they perform . It is totally dependent on basic nursing care. Because if you can make sure that the patient is washed, you know to the best of your ability

> has been positioned, has been put in a chair and encouraged to be ambulatory as well as some of those procedures and you will be happy. Some of those other procedures might have to wait a little bit. There is more time to squeeze them in.... So I think a lot of my evaluation is about basic nursing. How important the student thinks those things are rather than putting so much emphasis on procedures. (P5)

In the majority of cases reported in another study, the final grading of the clinical experience was decided by the faculty member (Kirkpatric et al, 1991). In Nursing 403/404, the clinical practicum is evaluated on a pass/fail basis and generally mutually determined by the faculty member and the preceptor. It may or may not contribute to the final grade depending on the specific faculty member involved.

Role Model

Preceptors allow students to work with them as partners during the preceptorship relationship. As reported in the literature (Campbell, Larrivee, Field, Day & Reutter, 1994), students try to emulate the behaviour of nurses who are supportive, patient, organized, and who maintain good relationship with patients, staff and students. Students also admired and respected nurses who were competent in their practice and demonstrated caring in their work with patients. The faculty member or the nurse manager who selected a preceptor hoped that the particular preceptor would demonstrate positive things about nursing that the student would strive to incorporate into his/her professional life. A faculty member said:

> Ten weeks of full time nursing. That is a lot of hours and the student wanting to excel and do a good job. Sometimes one of the things that happens to students is that they will do what the preceptor does because they want to please the preceptor and so it is so keen that the preceptor is a good role model and some of

them really are.... (F2)

Another one said:

> And really what they are like is something like clinical role models. With the senior students they have to give some kind of orientation and guidelines when they first start but by the end of the orientation they are very much into it. I think certainly it helps students. I think it is absolutely, totally necessary to have someone alongside them all the time because a lot of the work we are doing is role modelling the nurse's role for them as you help or assist them with the care planning. Or they can come up to say something. And if you help them with problem solving and if you just give them an answer, you are always trying to prove to them that you are there. When you take students into the hospital unit and they get to know that they are wonderful people, good nurses, excellent role models then you know that every student you place with them will be safe and learn a lot and will have a wonderful experience. You just know it will be wonderful. They could be friends for life. (F4)

Students learn from preceptors how staff nurses interact with patients, doctors and other health professionals as well as how to deal with interdisciplinary and organizational conflicts (Dibert & Goldenberg, 1995; Hayes, 1994). Many of the narrative accounts of the students suggested that they wanted someone they could identify with as they moved from the student's role to that of the graduate. The preceptor in the final nursing practicum, just before graduation, has been viewed by students in the study as the person who assisted them to cope with the realities in nursing practice and fostered their confidence. One student said:

> I respected her competence and confidence. Confidence goes a long way, and she really cared about her patients which I really respected. I saw doctors go up one side of her and down the other but she is very calmly composed and will say, "You are not listening to what I am saying, and what I am trying to tell you is..." and she will be so calm and I was so impressed. The other thing is the way she worked with the staff. She was a very good team member and very supportive of other people on staff. She was really a good role model. I couldn't have asked for somebody really better. She was good! (S3)

Another student, in answer to the question "What do you admire about your preceptor and would like to emulate?", said:

> This preceptor is very good and she doesn't get agitated even when there are a thousand things going wrong in the unit. She still stays calm and goes about doing whatever needs to be done. She can do things quickly but you don't even notice she is doing them quickly because she appears to be relaxed, although I know she isn't and she says she gets really up tight but it is not apparent to the patient, and this is really important. She listens to her patients and spends time talking to them. In my other unit there was no time talking to patients, absolutely none at all... In this unit my preceptor would often ask patients,"Do you have any concerns about the test you are to go through tomorrow?" Yes she anticipates, and often she is in there when the doctors talk to the patients and when the doctors finish she fills in the cracks, things that she sees missing. Everything was always in perspective and whenever you say "That patient is too hard and difficult to deal with" she will say, "Well, you got to remember these people have been in hospital for a long time and they are so scared. They have got this prognosis and it is difficult". (S1)

A third student concluded:

> And my other preceptor was so great. She has such a bedside manner that I think I really had the best. One who had the knowledge and the other one who had the bedside manner.... So watching her with the patients was a real treat because I feel like I can nurse quite well but she just conducted with the patients so I will just step back and watch because it was wonderful to watch her. And most of the patients will say, "She is my favourite, she is my favourite" and I will say, "She is my favourite too!". (S5)

All of the preceptors in the study perceived role modelling as their foremost role:

> I think the role of the preceptor is a role model in terms of having them watch you, how you interact. Many times I have had students come up to me and say, "I just want to be just like you". You know, because you can show them that in the care situation. (P5)

> It is just to be a role model and then show the different care that we give in our special area. Basically, in a nutshell, that is what it is. (P2)

> Well being a nurse for quite a while, I have been a preceptor for a few times. My main objective is to be a role model to them, help them gain knowledge to become appropriate nurses after they finish. (P1)

> I have preceptored many students out of the school of nursing and the degree classes and my role is to help them in gaining clinical experience as they can and to be on their own to become nurses in the field. The preceptor must be a good role model because everyone needs a role model. A child needs a role model so if you get them over and make them less scared to try things that are scary in a hospital setting, it is good. I have to make sure that care gets done and I have to oversee everything. I think you have to be a good role model too to your peers. If you are somebody that is not respected by your peers, then it is impossible to have respect from your student. (P3)

The role model aspect of preceptorship was highly valued by the preceptors who were interviewed. Referring to their statements, being a role model meant demonstrating appropriate clinical skills and judgment, having good organizational ability, good communication skills, caring attitudes, earning the respect of one's colleagues and exhibiting genuine concern for the student. When students internalize these concepts, they are able to identify with the role of the preceptor thus leading to the acquisition of a similar role for themselves in the future. On the other hand a preceptor who is not professionally committed could be a bad role model for the student. One preceptor said:

> "Hey, hey, hey! I want to be a preceptor" put my hand up and volunteer but nobody comes and says "Is this really a good nurse to be a role model for Joe Blow?" We had a situation on the ward where a nurse who we did not think was professional in the whole world, was going to be a preceptor. She just assigned the student and true enough the student started showing up late just like the nurse did. She will take her for long coffee breaks. One day the student did not show up for work for two hours. She kind of wandered into the unit and laughed, laughed and said "Oh my alarm did not come on". Yet she did not call to alert the unit or anything. Her preceptor said "Oh well let us go for coffee and we will talk about it". I hesitated and said"Let us talk about some professionalism here. The student did not show up for work for two hours and you are laughing about it. I do not think it is appropriate to go for coffee.

Situations like this come up at times when the preceptor may not be an ideal role model for the student. However, a student in the fourth year who is responsible and committed

to her/his studies can differentiate between desirable and undesirable attitudes toward work. Of concern could be a situation where a weak student is paired with a preceptor with poor clinical skills. The student's weaknesses would not be recognized or addressed and the faculty supervisor not made aware of any problem. A clinical incompetent student could pass.

Alliance for Future Job Opportunities

Faculty have observed that the role of the preceptor at times extended beyond helping the student to adjust to the staff nurse's role to that of assisting the student to secure a job. This role of the preceptor as offering potential job employment is identified in the literature (Hovey, 1990). A faculty member explained:

> Quite a few of these preceptorships could turn into a job for graduates. So there is a real positive side. It is like,"You have been with us for several weeks. If we hire you now we are not going to spend time on orientation. We know you. We like you. We know you are safe." So it will turn into a job for the undergraduate. (F3)

And another one concluded:

> This preceptor was tremendously involved and helping her out in her personal life. So sometimes the preceptor role extends beyond not just the professional role but also into the personal life of the students in helping them out. Often students in this course are taught by preceptors as to how to apply for their future work. (F4)

Preceptors said that they often recommended students they have preceptored for employment in their unit. If they think the student is good and there is a vacancy available, the student would be suggested because they wanted to keep good nurses in their units. They often offered to provide references for students who were seeking employment.

> Not always but sometimes they get employed because of preceptorship....The student you will be meeting tomorrow was employed because of our preceptorship. She was with me for 3 months on the unit and learned everything she has to learn and impressed the heck out of me and impressed the heck out of the staff on my unit and at the end of the 3 months we said, "We don't want to lose you. Let's find a way for you to work here". So she was hired into our casual float pool. (P5)

Another preceptor said of the student she preceptored:

> She looks at you like a teacher and with me I say, "She was my student before". And for my last student I knew she was applying for a job and I told her that "You could use me as a reference. If they like to know how you did in your preceptorship, you could always use me as a reference. I will be glad to give you a reference". (P1)

One student confirnmed:

> I got a job even before I finished. I got the work less than a month about three weeks and they had said to me a job was going to be posted. I am like "I am not done" and they said " No! You should apply anyway. You should apply". I kept going down and looking and I couldn't find it. And my preceptor said, "It is up, look". So we went up and checked and it was the weekend before... My preceptor said she will put reference for me. "She said I know you and I like you, you are good so I will give you my name as a reference" and I got called, interviewed and had the job. (S5)

The preceptorship relationship in some cases becomes an everlasting one, with the preceptor continuing to give support to the student for a long time after the experience.

Orientation of Students

Preceptors assisted students in adjusting to the clinical environment and in learning the rules and the routines of the unit. The friendly interaction from the preceptor in the process of the orientation reduced students' stress levels and fostered learning.

> On the first day I normally just let them know the type of area that we work, like I

> work in --- and stuff like that. If she is familiar with those things , I usually don't give her very much except to orientate her to the place. First of all I have to introduce her to my colleagues to let them know that I am working with a student so that they will cooperate with the student. On the second day I will give her one patient and would ask her how much confidence she has taking care of one patient. (P1)

> A lot of orientation is involved. While we do day shift the first couple of shifts we will work together but as we progress she may take one or two patients because suddenly there is a slow boredom when she knows she can do more than just work with me. When we go on night shift, there is orientation again because there is another routine that we have to go through. Then she will turn up taking like my full assignment of 6 people. (P3)

The first few days were used to settle in. The preceptors and the students got to know each other and the students were given time to get comfortable with the unit. Preceptors ensured students knew where to park, go for meals, where to change and where to rest. Hayes (1994) has reported similar orientation activities of preceptors.

Socialization of Students into the Nursing Profession

The preceptor is a kind of workplace socializer. The student having been labelled as a student for a long time needs somebody to make her believe in herself as a nurse. Preceptorship provides the role socialization needed to become an independent and accountable practitioner able to deal effectively with professional -bureaucratic conflicts (Hovey, 1990). Being with a preceptor helps the student's transition to nursing in the real world. Socialization into the real world of nursing decreases reality shock for the student. A faculty member attested:

> Preceptorship helps with the transition into being an independent nurse on their own.... Preceptorship at this point in the program, to the student, is more like a brand new employee starting in a new hospital and a new area and having to work

> with the existing people to become used to the new area and to improve in the clinical area. In many ways, it is like the real world and in many ways sort of preparing the students to be on their own when they graduate. (F 1)

Another one said:

> When student is placed with a preceptor, the student's feeling to become a nurse is increased if the preceptor is committed and enthusiastic about being in nursing. This is very important because the student spends so much time with the preceptor in the senior level, spending about four hundred hours (ten weeks of full time nursing). The other important thing is that a preceptor recognizes that there is professional responsibility and passes on to the student things like professionalism, accountability and reliability and how the student sees her/his role as a nurse and her/his responsibilities not to a particular patient but to society as a whole. (F2)

This particular category has been stressed more by faculty members than by any other group.

Reflections on the Preceptor Role

Preceptorship in nursing is a process whereby an experienced clinically competent nurse assists the student nurse in acquisition of skills and nursing knowledge. To accomplish these purposes, the preceptor assumes different roles. In this study, there is congruency in what faculty, students and preceptors identified as the roles of the preceptor. Role modelling of the nursing profession, teaching of hands-on-nursing skills and clinical judgment, supporting the student in the clinical setting, evaluation of the student on acquisition of clinical skills and knowledge, and alliance for future job opportunities have been identified by all three groups as integral to the role of the preceptor. Orientation of the student to the unit and socialization of the student into

nursing were mentioned often enough to be defined in separate categories. Orientation of student may, however, be conceptualized as an extension of the support role of preceptors while socialization may be viewed as being embodied in the role model role. The five roles identified by all the participant groups are significant as there is the implication that, in any successful preceptorship program, the preceptor should play these basic roles. From the study findings, the preceptor can play these basic roles successfully only when there is faculty and administrative support.

CHAPTER FIVE

Factors Influencing the Quality of the Preceptorship Experience

In this chapter, the research questions relating to factors facilitating or inhibiting the preceptorship experience are addressed. What was interesting in the analysis of data was the form in which these factors appeared. Barriers to high quality experiences were often the opposite to what were described as factors facilitating good experiences. One might hypothesize that issues related to preceptorship could be conceptualized along continua with the optimal manifestation of the factor at one end and the other end as almost the polar opposite. Taking student factors as an example, the following depiction could be made:

Facilitating	**Inhibiting**
Highly motivated student who is self -directed, accountable and knowledgeable ←---------- ----------→	*Student with little knowledge, little self-awareness, poor motivation and irresponsible*

Where the student fits on the continuum would be conceptualized as a factor influencing the quality of the preceptorship experience. Such a conceptualization of all factors affecting the quality of the preceptorship experience might be useful for predicting early in

the preceptorship experience that the balance of factors is skewed very positively and thus likely to lead a satisfying experience or skewed very negatively and thus requiring faculty intervention in the best interest of both preceptor and student.

The issues arising out of the data provide insight as to how faculty could improve the effectiveness of preceptorship experiences of senior nursing students. A few issues of importance to preceptorship but not directly related to the quality of the experience, were also raised and will be presented.

Findings Relating to Faculty, Student and Preceptor Perceptions of Factors Affecting Preceptorship Satisfaction

In the faculty of nursing providing the site for this research, preceptorship is an integral part of the socialization of senior nursing students into their professional roles and responsibilities. Data collection for this study, however, revealed many areas in which improvements could be made. Comments from the respondents were identified and transformed into categories. The perceptions of the groups did not differ very much. The narrative summary which follows is based on congruency of themes among the groups.

In describing the issues emerging from the data in the remainder of this chapter, categories as perceived by faculty, students and preceptors will be discussed together as, with few exceptions, the major issues were identified by at least two groups of participants. Communication, receptiveness to taking students, faculty commitment, planning in advance, fitness between student and preceptor, competence of the unit

manager, faculty appreciation of preceptors' contributions and the ability/ knowledge/ motivation of students are the issues that will be addressed. What needs to be acknowledged is that health reform was in progress at the time of data collection and that factors beyond the level of the hospital unit impacted upon the findings. Features of the health care system affected the quality of the preceptorship experience

Open lines of Communication

The establishment of an effective communication network among instructor, student, preceptor and unit manager was viewed by the study participants as crucial to the preceptorship experience. Written documentation on the student and a description of the nature and scope of the experience should be made available to the preceptor. Faculty should maintain communication with the preceptor and the student. In most cases preceptors expressed stress related to what was expected of them. Whether they would be able to meet the criteria were sources of anxiety to preceptors. Personal contact and frequent telephone calls from faculty helped ease the tension in most cases, a point that has been made in the literature (Andrusyszyn & Maltby, 1993; Peirce, 1991). A faculty member explained:

> I think one of the things that becomes a faculty responsibility is to actually work with the preceptor so that you can contact them. Well, the first thing I do is send them a course outline and the course outline has a section that talks about roles and responsibilities of the preceptor. I might spend an hour or more meeting with the preceptor. Just answering questions about the course outline and the questions that they have. And then that will be one of the first things. It seems to work well because it sort of gives them a framework and on the specific course outline they see what the student objectives are. The other thing that I have done is also for all students to write out their own learning objectives and clinical experiences that

> they wanted to have and bring them to me and I make some suggestions and then they send them back to the preceptor. And sometimes the three of us might meet but at times just the two of them. I will follow up with a meeting or a phone call with the preceptor. Um and then I will spend additional time maybe showing and asking if they have any concerns. Sometimes I might offer information and articles....The other thing that I do is every two weeks we have a seminar and I get students to share what their experiences have been like in the clinical setting. And I also use a journal. Sometimes I pick things up in the journal... (F2).

And another one said:

> I think that another reason too is that there is a real need for communication. First of all, the preceptor has to get good information about the student; the name, the telephone number, the name of the course, and what the purpose of the course is. And they need to know how many forms. " How many evaluation forms are we going to fill out? When is the evaluation due?" So the preceptor needs to know a lot of information ahead of time. And the students have quite often helped the preceptor understand some of it. Some of it, so the student and the teacher have to help the preceptor to understand what their role is. And then there has to be the communication and this is where you should get into three way triangle communication. (F1)

Another faculty member concluded:

> It works so well for the student, the preceptor and the instructor to talk because we all sort of pull things out and then it really is nice and an integrated course. I try to really keep close contact especially at the beginning with my preceptor and student although and I do go to see them the ones that are within travelling distance. (F4)

A student maintained that:

> Yeah, she was really a good instructor and at the beginning of the rotation she sent up a package to the hospital and to the preceptor about what our expectations were and what I needed and stuff like that. And before we went up to our placement we sat down and had to write a personal draft of what we wanted to achieve during our preceptorship. She went over those with us as well and .... she will say "You might want to be thinking about this? And what about that?" She was instrumental in a lot of us getting interested in our IV certification. And ----- college has a self study course where you write an exam and you have to get 3 supervised stats and she was instrumental in setting that up for us so that we could all get through the training during our rotation which was another good thing. (S3)

Another student observed:

> One other thing that I think is important with the preceptorship is that the instructor should sit down with the student and make a list of the experiences that the student has had. Especially, with us the instructor has never seen us before and we transferred from ---- hospital. We had a different experience there compared to the ----- hospital. We should have made a list of the experiences we had and what we needed and then try to pair up the need with the appropriate unit. (S1)

A preceptor stressed that good communication was very crucial to the success of the preceptorship relationship by the following statement:

> Uh, it depends on the instructors and how busy they are. I usually have two contacts when I have students. This is the third time I have been contacted by this particular instructor. It was more on the process of trying to get hold of me so we can get together to talk about the student. (P4)

Congruent with what has been reported in the literature (Davis & Barham, 1989), it was necessary that all the individuals involved in the preceptor relationship understood the communication channels and used them effectively.

The first theme identified by all the groups as an impeding factor on preceptorship was poor communication between nursing education and nursing service or in the instructor, student and preceptor triad. When communication is poor, small problems can escalate into major concerns. A faculty member said:

> Well, I think what didn't happen in most cases is the preceptor being notified of their role and role expectations before that last moment.... Preceptors don't have enough time to think about their roles before students arrive on the unit, making things difficult for preceptors as well as students. (F3)

Another faculty member deliberated on the issue of communication:

> Quite often, nurses won't tell you anything until the student sort of you know, or something terrible happens when you hear....you know that there is a line there and you have to let the preceptor know that they can tell you anything anytime if there

> is anything. Say that, "I don't know these students, they come with clean record or whatever but if any problems come up, don't worry just contact me". You know, so preceptors have to know whether it is okay to tell on students because we don't tell on people here. (F1)

This faculty member continued with:

> It can be a problem with the student, a problem with the teacher and a problem with the preceptor. When that kind of communication process involving all three is lacking...the student will hope the preceptor will tell you everything and the student won't tell you anything. The preceptor thinks the student tells you something, and you can get into serious problems so communication from the instructor is very critical. For preceptors who are working nights and weekends, it means a lot of work for the instructor to keep following up. (F1)

One student commented on poor communication on the side of the instructor by saying:

> Uh, my first placement I had was in a surgical unit and I found that my instructor for the course never informed the preceptor ahead of time and I would have thought there would be some understanding of where I was with my program. (S4)

Another student said:

> My instructor never came or called the unit. Her buddy or Teaching Assistant came to the unit but she was not very active. You know what I mean. She just paired you up with your preceptor and you just walk there with your preceptor. And any assignment, you just hand it over to the instructor. (S2)

A third student reported:

> I never had the chance of meeting with my preceptor and instructor. They often met in my absence so I phoned my instructor about that and she said "Yes, I understand that" but the next meeting, I was not there and I thought it was very unprofessional and I felt very frustrated. (S1)

One preceptor who was not happy about the way faculty was communicating with her

unit said:

> You receive a piece of paper that says, "By the end of this course, we expect student so and so should be able to accomplish the following objectives" and the preceptor should receive this before they agree to be a preceptor because maybe there might be something on there that they are not comfortable with or too much of a job. You know a lot of time on our unit we are assigned students randomly and there are group of us that are willing to participate and we don't necessarily know in advance what particular course a student might be taking. (P5)

Poor communication has made preceptorship experience rather disasterous for many students despite the fact that their preceptors knew what they were about, a point made clear by Lewis (1986). Lack of open communication in the preceptorship relationship makes it difficult for both student and preceptor to collaborate. The student (S1) said she felt very frustrated because she wanted to have a dialogue with both the preceptor and the faculty member on her experience on the unit but she was never given that opportunity. Preceptor concerns about a student at the beginning of the rotation may not be communicated early enough for faculty to intervene effectively in facilitating student learning and improvement. Student failure or a highly conflictual experience can result.

Preceptor Willingness to Take Students

The importance of preceptor willingness to take students was well recognized by all of the groups. The study participants were very concerned about the preceptor's enthusiasm regarding having students.That preceptors must demonstrate interest to support and teach others has been reported in the literature (Peirce, 1991; Young, Theriault & Collins, 1989). Preceptors who were enthusiastic about having students and

who were warm and receptive to the students facilitated the students' comfort and adjustment to the clinical setting. Faculty members expressed the need for enthusiastic preceptors in different ways:

> I can go on to the negative, but the ones that did well and most of them, both myself and the students saw them as good preceptors were those interested in students.They were interested in the precepting... . A lot of them really enjoy students, enjoy watching that kind of growth within a short period of time and were interested in what the students were learning. So I guess it is interest in learning, interest in what students are learning and in what the students can contribute as well. Encouraging students to be on their own. (F1)

> What makes me feel good about preceptors is when they themselves are committed and are enthusiastic about being in nursing and their ability to work with people...they might have students because they say "I am enjoying, the students keep me on my toes. They always ask me questions that make me think about why I am doing this or why we are doing that" another said, "Students really make me think about the nursing care that I give". So they appreciate that and they want students. (F2)

> Some of the nurses look on and the responses are great. Some would say, "I mean I know how helpful students can be, and I like having students, I am going to take one". (F3)

> I am always amazed at the depth that they can go with students. And it is difficult at times because those nurses are working long hours and they do a lot of things and yet they spend extra hours to talk to students or stay extra hours to go over a particular skill like central lines , blood drawing or something. (F4)

A student said:

> Like they have to be willing to spend their time with the student to help the student learn and to give the student enough room to do the stuff, to make mistakes in what they have to do and to help them see the mistakes they make and how not to do it. Of course not serious mistakes but minor mistakes. Or just give them enough room to be on their own but be around when they need them. Uh, they have to have good communication skills. (S1)

Another student affirmed:

> For me it was just the type of people they were. They were very open and very giving and they were really into putting their reputation in there. Like take the time to teach you and I was really receptive to that. They respected me as a student and they trusted me. A lot of time I say, "I am drawing this medication. Do you want to look?" and she will say "I have seen you do it a million times and you got it a million times right, go ahead. I trust you" and they said that million times over and that was tremendous. (S5).

And a preceptor confirmed:

> Like I have been doing it for 13 years but I never really thought about it . It is like you know, I think the program is great. I think it really helps mould the students to come into the work force but I think they have to be put with someone who appreciates this. As someone new who needs a lot of guidance and lot of supervision, you are still ultimately responsible for their assignment. So that, you take it slow at the beginning and see what they can do. You will be able to gauge how they are progressing as well as their weaknesses. (P4)

Another preceptor said:

> My supervisor she was, I am not sure how that works but she knew that the students would be coming. And I have always been a good morale booster at work, getting along easily with people and I love to teach people. I catch on fast so she just asked me if I mind doing it and I said it was just great. And every 3 to 4 months I have a student that I am precepting with. It opens your eyes too, like it makes me think about a lot of things because they are asking questions about some medications and you think more "why is that". It is a teaching/learning experience for me too. (P3)

In contrast, preceptors not being receptive to students made students dislike preceptorship experiences (Peirce,1991). This could stem from the fact that the staff nurse had no interest in taking a student or because the unit manager had not respected the wishes of the staff nurse. In some instances, a faculty member suggested, some of the nurses signed up to be preceptors not for the purpose of helping the student but to have the student work for them. She affirmed :

> Sometimes what I have run into is a preceptor who says "Yes" but she only wants students there to take care of her patients and she wouldn't teach them. She wouldn't do anything else because she wouldn't give them time at all...that was bad because the student felt bad...but actually when I talked to the preceptor she just said, "Well, look! Do you know what my work load is? I wanted students because I want them to take over my patients". (F4)

Another faculty participant reported that a student was told by a preceptor:

> "I have to do this because or I lose my job". (F3)

One preceptor said:

> The faculty doesn't interview to find out whether you are good. What you think you are good at... but nobody comes and says "Is this really a good nurse to be a role model for ----?" (P5)

One student declared:

> It was hard for me to finish up that first surgical unit. I just shook my head...I just think she is a nightmare....She doesn't want to put any effort into it. She has some knowledge but she doesn't go home and look up things.... I think it is important to get to places where the nurses are still happy to go to work, happy to help students, happy to share what they know and care. (S4)

This observation, while connected to preceptor commitment and enthusiasm, may be more related to staff morale. Students need experiences where nursing staff are highly motivated and committed to good patient care. Another student attested:

> I mean a lot of preceptors that I have heard, you know we just talk, would say, "I wish to have students so that they can do my work". (S5)

To make the preceptorial experience exciting and beneficial for the students, it is prudent to ask preceptors to give their consent before assigning students to them. Registering their interest and consent would be an indication of their willingness to guide and support students. Attracting adequate numbers of competent and interested

preceptors, however, can be difficult in times of health care reform when nurses are losing jobs, being transferred to new units or asked to assume new responsibilities. Thus social factors beyond the control of individual nurses may influence willingness to precept students. In times of massive change or budget cutbacks, guiding a student nurse may be perceived as an additional stressor.

Faculty Commitment/Familiarity with Site

The importance of direction and guidance from faculty cannot be overemphasized. As Peirce (1991) suggests, it was necessary that faculty members presented a clear program and made themselves accessible at all times during the relationship. Attempts to be available in the clinical setting were appreciated. Ferguson (1996) states that it is a faculty responsibility to orientate preceptors before they assume the role.

A faculty member asserted:

> Well, I thought one should be committed to it in many ways. I think it is very good for soon to graduate students. You know that they can have a one-on-one kind of thing. For most of them it is just like being oriented. It is a lot of fun and it is important that the teacher is positive about it and says, "Oh you are going see so much, or going to really enjoy yourselves". It helps sometimes. You see a lot of my students who go to the ---- ---- or ---- ---- and I have been working in this community for so long that I say, "Oh that is it I know ____ she is a great nurse". Things like that, being positive about it, is absolutely critical and I think that's one of the main things, being positive about it. And that you know students seem being into it, preceptor being into it, and a lot of busy work, a lot of talking. A lot of talking and busy work and trust, trusting that things will go well. (F3)

Another faculty member said:

> I think it is absolutely totally necessary to have someone alongside them all the time. Uh because a lot of the work we are doing is role modelling, the nurse role for them as you help or assist them with the care, planning or how they can come

> up to say something and help them with problem solving and if you just give them an answer you are always trying to prove to them you are there... I guess I think that the preceptor is a sort of uh, no, I was going to say an extension of me but I don't mean that, I mean something like that you know because I deeply care for nursing and nursing practice and ideally I would probably like to be out there with them. (F4)

One student, in a reply to what her instructor did to make her experience a success, made the following statement:

> Nothing whatsoever. I don't have any nice things to say about her. The experience that I had was made by myself. I had to seek forth the experience and I put it forth to my preceptor that "This is what I am expecting"... There were sort of little things that my instructor didn't do like contact my preceptors before, introduce herself, she did not do any of that. She never came up to the unit to see how I was doing, none of that. I thought that was really poor professional behaviour. I don't think she played any part in it at all. She could have. I have heard of other instructors who have been quite on top of stuff like that and mine has been a trial rather than having your instructor as part of it. (S5)

Related to the commitment was faculty familiarity with the site and the people.It was prudent for faculty to be familiar with the unit and be familiar with the staff. Being familiar with the unit provided a menu of experience that the student would have and also aided in assisting students to set their learning objectives and organize their learning opportunities. Clinical experience should give the student an in-depth learning in the clinical setting and not just an exposure to the clients and the unit (Oermann, 1994). Committed faculty make the effort to know the units and staff with which students will be gaining experience. From the students' point of view, clinical staff tended to treat students in a positive way if their instructor was known to the staff. Faculty asserted:

> I think the best thing to do is to have a very clear understanding of and to know the people in the site, know what kind of experiences there are , know the contact people... I think also if you use the same sites then of course you tend to know

> people and this makes things easier and kind of saves time I guess. Contact is the number one key thing and making sure that if they have not preceptored before they can ask somebody they are working with "Were you a preceptor last year and how was that?" So they probably need a lot of up-front encouragement. (F3)

> I think you have to work closely with your managers and your supervisors of that particular area where you are placing the student because they can pick up which nurses will be good preceptors.You know like I mean you don't want someone who is going to scare the hell out of them. There are a lot of nurses there that are overbearing and students are scared to work with them. (F2)

A student commented :

> But I think the instructors have to be familiar with what is going on in these units in order to match the student's need and level with what is going on in that unit. Because otherwise, if you put a student to the unit it can be a burden to the unit....The instructor should be aware of what is going on in the unit and what the student's background is and to match them, and I think that is very important...and if they know the instructor that may have impact on the way they treat the students because, if they knew the instructor, things might have been different. I have been told that the staff in the units really respect the fact that the instructors in the past came up to spend a day or two in the unit before they sent the students. (S1)

On the other hand if the faculty member is not familiar with the unit and the people, it goes against the students. The following is an observations made by a student:

> ------didn't really know much about the hospital because she is not even in town. All the time she is in---- which is fine but people here don't know her. She doesn't know people here. More so, about clinical issues, she is not informed. I don't see her as the best person for that because she is not in the clinical areas anymore so issues that come up like I am sure she can't help you much. -----. She did not understand what I was saying because she has not been in that unit. One of my former instructors however, went to the unit and worked three or four shifts before taking us there. She gave us procedures and really coaxed us through them. It is important for the instructor to be comfortable with the nursing practice in the student placement. (S4)

This quote suggests that not only do faculty have to be committed and interested, they also need to have clinical competence in the type of nursing expected in the area in which

the student has been placed. This can be an issue when limited placements are available and faculty must then take responsibility for working with students and preceptors in the absence of faculty understanding of clinical nursing requirements of a specific specialty. A balance needs to be struck in three areas; student placements, preceptorship assignments and faculty expertise. What is optimal may not always be possible.

Student Knows the Unit of Placement

All student participants expressed their concern about knowing the unit ahead of time so that they could prepare by reading about conditions and procedures common to the unit. A similar theme emerged in Peirce's study (1991) on preceptorial students' views of their clinical experiences. Some of the students in my study suggested that students be allowed a one day working visit to the unit prior to placement:

> When you get an idea about where you are going to while you are reading, like we had 3 weeks .... before we started this which I think it is a waste of time because I didn't know where I was going and I did not know what to read so I mean what are you supposed to read about? It didn't have anything set up, and I was lazy because I didn't know where I was going and I didn't have that much hope that I will end up anywhere...If you don't know the unit, you don't know what skills you need to be reading about or what diseases like we have a lot of diseases, like in ---- we get diseases there that you don't know anything about. They are complicated like the different tests they do and it is just a very complex diagnosis and to go home after 12 hours and read and even if you are on 2 days off to read. It is hard. It would have been easier had I known like "This is where you are going" and they gave me 3 diseases that might have come up that you should be reading about and 6 medications that are given out all the time to know. Like to have 6 medications that you are giving all the time or 6 things that you do all the time like opening central lines all the time. Reading about it will prepare you and you can at least look intelligent to your preceptor. When you get there you will say "I have read this and this, do you guys do that" so that you can be seen as being sort of credible rather than "Why are you guys doing this?" all the time. "What do I have to know about it ?" You know. (S4)

> Uh, probably the only thing, and really it wasn't her fault I guess was one of those things. I could not find out until a week before I have to leave that I actually have a placement and a preceptor and something like that. And that was kind of frustrating because I was like "Okay if I am not going there, then where am I going?" Like I wanted to know because I didn't want to get stuck in somewhere that I wasn't interested in. (S3)

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Another student who had the previlege to be at the unit ahead of time commented:

> I was there a week and a half before I even started officially. I said, "I don't know if I am here but I think I am so what is this unit about? What material do I have to read or an orientation package? What kind of symptom diseases do you see on the whole that I can know as much as I can read the material?" So I made myself available even before it started. (S5)

Students have expressed their concerns about last minute placements which in many instances were not the fault of the faculty. This tends to have negative effects on students if the preceptor is not a caring person and aware of student concern with last minute placements. A student declared:

> But I only knew of the placement like two days before I was sent there. I bounced from unit to unit. It was a nightmare. I can talk to you about an hour on that issue. ... I got shambled and I got upset and I said I was ready to take my money and go somewhere else. I was really angry. (S4)

A faculty member affirmed this problem, declaring:

> I had students here on Friday, students who were getting ready to go into the clinical but there was still this one student that on Friday afternoon who had not got a placement. And she had to go on Monday but however it finally came through on Friday. So I think a little bit of time will be better for faculty and students. (F2)

Another faculty member claimed:

> We try to get placement six months, nine months ahead but the system changes so quickly that by the time you are ready to in there, the units are there but the staff you want to put the student with is long gone....It doesn't do the student any good but that is an administrative thing. (F3)

This issue of last minute placement is not always related to a lack of planning. When units are closing and staff are being transferred among units or there are few full-time nurses experienced in the area, delays in finalizing placements are inevitable. This is frustrating for students, faculty and preceptors alike. Often faculty are blamed even when the situation is out of their control.

Fitness Between Student and Preceptor

This was identified by both students and preceptors as an issue in preceptorship that had much influence on the success of the relationship. Fitness in this case could be based on many dimensions such as physique, temperament, attitude and beliefs, or type of program. In the case of type of program, in this study it has been observed that baccalaureate nursing students were being preceptored by staff nurses prepared in the diploma program. This could be a source of conflict between preceptor and preceptee. When somebody who has gone through a baccalaureate program precepts a student in the program there may be better understanding of what the degree program is trying to achieve and thus a more realistic appraisal of student performance. In the same manner, personal beliefs and attitude of preceptor and preceptee may agree or totally conflict with each other.

The other issue is that a preceptor and student may fit each other at the negative

side of the professionalism continuum. As sited in the case of an irresponsible preceptor fitting well with an irresponsible student. This type of fitness is dangerous to the nursing profession. Whether a student and a preceptor would fit was not always easy to predict when making the placement. However, there is always the hope that the student learning needs will be met and client care enhanced.

A preceptor said:

> Well, the student you will meet tomorrow ... . She was with me for three months on the unit and learned everything she had to learn and impressed the heck out of me and impressed the heck out of the staff on my unit....(P5)

Another preceptor stated:

> Sometimes, it can be a life long friendship but then it depends on how well you got along at that time....One I keep in contact with till now. We seemed to get along quite well so I keep contact with her. (P2)

Students' views on fitness were as follows:

> She provided me with guidance and support. She taught me a lot of stuff and provided me with constructive criticism. She will never let me get away with things that were not appropriate, but she wasn't condemning when she was providing me with criticism and stuff like that so that was good. And she was like a liaison for me as well because I had a couple of incidents with one of the nurses in particular. This nurse, just couldn't see eye to eye with me. We ended up having hands a little bit and my preceptor kind of played an intermediary role. She stepped in at one point when she thought that nurse and I had gone a little bit out of hand. She said we needed to sit down and talk to the head nurse and we ended up having a conference and that was good. (S3)

A second student concluded:

> And this nurse, (new preceptor) strangely the first day I was there we went to a workshop on team leading and we had to pick up an issue that we had problem with in the unit, that we have had a kind of difference of opinion on, what topic was it and how we dealt with it. It turned out that my new preceptor put down "pain medication" and I had put that down too and I thought, "Wow! I have finally found a person that holds the same beliefs that I hold". Like you know, you have

> two people agreeing together and they can work better. Here you are a team and you are working together, whereas before, I was always trying to keep in step with my other preceptor. (S1)

Another student described how she got to her unit:

> What happened was I was at the same spot a year ago or so doing my 203/204 no my 205 so I was on this unit for 205 and my first preceptor who I had little contact with came up to me and said, "Consider me for your preceptorship in your fourth year" and I looked at her like "You don't really know me what do you like about me?" What she liked about me specifically was that I made learning experiences and I sought information which is what I found in her. So she asked me to come back and I had no intention of doing it but I ran into her a couple of months before and she said "Are you still considering it?" and I said, "Oh well! Maybe we will see". (S5)

The preceptorship relationship prevails over some time and, when preceptors and students do not match, great tension is created. The experience becomes frustrating for both the preceptor and the student. Some students do portray certain traits that irritate their preceptors (Lewis, 1990). A preceptor said:

> There was an instance where a nurse that I worked with did not get along with her student so there is always personality conflict too. But it is hard to determine who will match who so you just have to take a chance. It is only a few weeks. It is not a lifetime experience . (P2)

Nevertheless, a preceptor who was very conscious of her own short stature asserted:

> The first question I ask is how tall is she? Because for one time I had an experience before with a tall nurse. Like I am only 5 feet and of course you cannot wear high heels at work so you cannot really lengthen up your height. My student was 5 feet 9 inches. When we got up to a patient, it was hard to work with a very tall person and not only that but for the patient as well. And I have to keep on tilting my head so I usually let her sit down so that I told her what to do and when we had a conference, we just talked like that because it was hard on my neck. I usually ask, "What is her height?". (P1)

One student commented:

> Temperament also enters into it. My previous nurse was very high power all the time. I said, "I don't think you ever have a low gear, you don't even have a medium, you only have high" and she said "Yes, sometimes my husband says I drive him nuts because I never sit down". And that temperament I don't think is suitable for a preceptor. They are very efficient and successful nurses but as preceptors, they can't slow down and allow students to think through things. (S1)

A faculty member observed:

> They learn all kinds of clinical tricks and they can pick up things that are not good habits. But by fours years they should be able to critically look at the practice and say "Yes, this is good practice!" that sort of thinking is important.

Competent and Committed Unit Manager

One other thing that was perceived by the students and the preceptors as an influencing factor was the unit manager. That the success of a preceptorship program depends very much on administrative support has been reported in the literature (Hsieh & Knowles, 1990; Young et al, 1989). Unit managers assess staff members' potential for preceptorship, hence affecting preceptorship by making the right selection (Davis & Barham, 1989). In addition, if the unit manager supported preceptorship, it made things easier for the preceptors and positively affected the student's experience. A well organized and well managed unit was conducive to learning. A preceptor's comment suggested that when the unit manager believed in preceptorship provisions were made for preceptors to have time with their students and the unit was organized to foster learning.

Students stated that:

> And the team works together. She is a team supervisor and I think that makes a big difference too. Because the staff and my preceptor being one of them, is more relaxed and more confident about doing what she is doing if she has a supervisor that is supportive. So that makes a big difference and the unit is so well organized. Everything is where it should be. There is a place for everything and all that you

> have to do is learn where it is supposed to be and it is always there. That is so different. I mean the auto set machine is always set, standing there and plugged in there and when you finish with it you put it back there. And if it is not there, somebody is using it. If we need a medication that hasn't come up on time, there is a little subsidiary pharmacy just around the corner from our side. We go and ask for it and take it back to the unit. With the other one, we had to call for them to send it up and it was very slow. And this works very well. This is a well run unit. There are charts on the wall on important data values for different blood levels and MI levels so you can make a quick reference. You don't have to go checking in the book. (S1)

> A system that they had up there that I really liked, and I actually have been able to carry over here is, uh they had a work sheet that they just divided into boxes... so that you knew what you are about for the day. You could look at the kardex and know what treatment you have to stop and you just make a note in the box so that was really good for organization. Like I said I have been able to carry that over here so that really helped me a lot with organization. (S3)

When the unit manager is incompetent, everything is disarrayed and this impedes preceptorship in terms of support for the preceptor and the student as well as not creating a conducive environment for teaching and learning. The majority of the preceptors were appointed by the unit managers yet on the duty roster the preceptors were in charge of the unit at times. This caused frustration in some of the preceptors because being a preceptor demanded an extra input to an already tight unit responsibility, a point made in the literature on preceptorship (Hayes; 1994). A preceptor complained:

> I have talked to her about it because sometimes I have been put in charge and I find that very difficult to be put in charge and also have a student and I am supposed to be doing 2 jobs and having a job with the student is not easy. When the student has not been keeping up to speed, it takes longer and to be also in charge is too much and so often the student gets put up with someone else because I can't do 2 jobs and that person, that RN may not know her as well, know what to expect of her and sometimes is not interested to watch her as she should and stuff like that. I have talked to her about that but she is not the only one that is in charge and often some one else who makes the schedule will come. And one thing is that the student is not considered as an RN on the unit and so I shouldn't have double assignment just because I have a student and still have my work. (P4)

A student declared:

> In my other unit the supervisor just assigned the patients, some days light load, some days impossible load. So the unit supervisor is another important thing. (S1)

Another student said:

> The unit, to me I thought when I was in ----, it was more organized than this place. In---- only one nurse did the medication for all the team so you are not bothered about medication. (S2)

Faculty Appreciation of Preceptor Service

Talking to faculty members about how they showed their appreciation for the services rendered by preceptors, they all said they had a way of showing appreciation for the good work that the preceptors were doing. This ranged from a faculty arranged tea to a free workshop for preceptors. This form of appreciation is congruent with what has been found in the literature (Hitchings, 1989). In this study, a faculty member attested:

> Somehow we thank them, I mean in---- what we used to do was to give them free tuition in one of the weekend courses but we haven't got that set up here...but we usually have a preceptor tea and a lot of them come and we have done that for two years...I find for myself an individual way of thanking them. I always give Florence Nightingale's Notes on Nursing with a "Thank you" letter. (F4)

Another one said:

> There is very little recognition. I do write a thank you letter and do a lot of positive encouragement during the course and thank them. Usually the students say "Oh, she is so great!" and I tell the preceptor and say, "Boy! I am just, you are so helpful, thank you very much". (F1)

A third one affirmed:

> I think it is important that you keep contact with them and I mean say thank you

> and that you appreciate it. I also write a "thank you" letter and sometimes I give things like chocolate to a preceptor just to say "thank you". Because I really do appreciate them taking students and providing extra learning experience for the students. I have got a number of students that do very nice things for their preceptors....because I think they deserve that kind of recognition. (F2).

When faculty choose to give gifts to preceptors, they pay for them themselves. This should not be expected of faculty. Many of the preceptors affirmed faculty recognition of their efforts except for one preceptor who claimed:

> Every student that I ever had always gave me some kind of little gift, a little card saying how much they enjoyed working with me but it would be nice too to have something from the faculty just saying that, "we appreciate your service,---- said you're such a fabulous preceptor". You know some sort of encouragement. (F5)

This was somebody who had precepted often and reported not having had any recognition from faculty. Goldenberg (1987/88) suggested that the added responsibility of preceptorship deserves an appropriate reward.

Motivated Student with Adequate Knowledge

Precepting an academically poor student was a major issue for preceptors. Lewis (1990) and Stevenson et al (1995) confirmed that with an academically poor student, extra time and energy are needed to bring the student to the required standard. In addition, the preceptor faces the dilemma of introducing an unsafe practitioner into the profession (Rittman & Osburn, 1995). Poor students increase stress and frustration in the preceptors. In this study one preceptor narrated:

> If the student is a poor student then the stress level is phenomenal and there is no one there, like to talk to , to tell you that you are doing a good job unless you have a really good team of nurses.... I was disappointed with faculty that the

> student has got that far and I think that is a direct response to not having a preceptor earlier on. (P5)

Another said:

> I have told her things but she just doesn't hear them and I will say "I told you this. You said yes and yet you are not following with me here" and she will say, "All I can figure out right now is this".... When it comes to the work situation she is totally lost. (P4)

A faculty member said:

> Don't give them students that you have not already prepared at least in the lab or with knowledge, with the theory and some practice so they go out having the thought and hands on practice.... So never send students that haven't had the preparation that they need for that particular area. And preceptors get really annoyed if they ask them questions constantly that they should have been taught or they could look up or whatever depending on how busy the unit is. They should not expect the preceptor to teach them all the theory. (F2)

Another explained:

> I guess when a preceptor decides a student can't pass or brings anything like that to your attention, you know for sure this has been going on for some time. But the preceptor has not been able to say it to you because she feels that she has failed in someway....If the student has been tremendously unsafe for practice and we have examples of that, we can sort of fail the student right away and she/he can reapply to come in. Or the other thing we have done is we hire an instructor for one-to-one with them. We also have them slip back a year or something. We put the student in a lower instructor clinical group so that she/he can relearn some of the skills and if she/he is successful then they can go again into the next course. I mean we have a student right now from---- who the preceptor could not pass as safe and competent. (F4)

Student aptitude and attitude are crucial factors influencing both student and preceptor satisfaction with preceptorship experiences. Preceptoring failing or borderline students is extremely stressful. Faculty may not be as supportive as is needed and, without orientation, preceptors may be inadequately prepared for working with such students.

Ancillary Findings

In the study findings, some themes that were not directly addressed by the research questions were raised. It is quite important to be sensitive to these ancillary findings as well. While acknowledging that these issues were not explored in depth in the interview, a brief overview of such data will be given. These categories of preceptor selection, preceptor reward, benefits of preceptorship and preparation of preceptors have implications for faculty and administrators involved in curriculum planning for preceptorship of clinical experiences for student nurses. Unlike the factors explored earlier in this chapter, these categories are oriented more to student groups than to individual students.

Preceptor Selection

Preceptor selection was an issue of concern for faculty because the preceptors were often selected by the unit managers and faculty were not sure of the criteria the administrators used in selecting preceptors . One faculty member said:

> Well, for the most part, it is an administrative thing where we know we have 10 students who need preceptors. We go to the hospital administrator... and the top administrator talks to the front line administrators and says, "Do you have any nurse who basically and hopefully wants to be a preceptor?" and number two "Are going to be around and be there for the students?" So these are the main criteria but in addition to that these are expert nurses who are in the unit and are good. (F1)

Another one commented:

> Sometimes you are not sure what criteria they use. They tend to use the most experienced ones. Quite often the most experienced ones have students and they have preceptored a lot and need rest ... (F3)

Another said:

> In many cases, faculty have to adopt a "begger can't be choosers" attitude as availability of sufficient qualified staff nurses may be limited. Staff nurses who plan long holidays during the student's rotation, for example, are not good choices. (F2)

Preceptor Reward

The literature indicates that preceptors' main rewards are intrinsic, such as opportunities to assist younger nurses in becoming part of the nursing profession, sharing knowledge, gaining teaching experience, protecting the nursing profession by being a good role model to novices and gaining personal satisfaction from such roles (Dibert & Goldenberg, 1995; Lewis, 1990). Preceptors in this study expressed similar views. One preceptor said:

> I get paid my hourly wage. Now I have got four hands instead of two and that makes things a lot easier. You get an asset of having somebody there to work with you. I don't know. I have never thought of monetary incentive. Of course, the students, for what they do, they do 12 hour shift, buy their own coffee and own lunch, transport and parking, get their own uniform and shoes. (P3)

Another preceptor's answer to the question, "Are you given any incentive for precepting?"

Said:

> No, no I don't really care about that although last time they gave us preceptors' tea at the university and that was something in appreciation. Normally the kids, the students they give you something but I don't really look forward to that, no. I like to share my knowledge with somebody and I have to have a positive attitude. Otherwise the students won't learn. (P1)

However, a student condended that:

> If they could pay them just a token amount or whatever, then they would have an increased sense of responsibility and then the student would feel like she was more entitled to demand their time, talking time or teaching time or whatever. Like now when you go, like I am always apologetic. I'm sorry to interrupt people and you are always sort of like "My God, I am interrupting again!" or whatever but if there were some kind of payment, I mean it would work better. (S4)

Faculty expressed:

> Like I have some ethical qualms about it actually because they are not being paid. In many ways the faculty saves money with preceptorship. Normally in the past, I would take nursing students into the clinical area, one teacher with 8 students but now you have preceptored students, one teacher with 24 students. (F1)

Preceptors have not come out asking for financial reward but many studies are now recommneding a formal reward for preceptors because it has generally been conceived that preceptors are doing a good job (O'Mara & Welton, 1995; Yonge et al, 1994). A suggestion made by staff nurses in home care (personal communication, Linda Ogilvie, December 4, 1996) has been to develop a point system for rewarding preceptors in which accumulation of a certain number of points would be accepted in lieu of tuition when preceptors enrol in university level nursing courses.

Benefits of Preceptorship

Preceptorship has many advantages to the educational institution, the service institution, the student and the preceptor (Chickerella & Lutz, 1981; Rittman, 1992). One faculty member affirmed:

> Well I think there are a lot of benefits. In terms of faculty, if you have students up with preceptor and the students do well on the job, it is a bonus to the faculty because the preceptor or other people in that unit will say University of --- faculty

> do a good job. They are obviously doing a good job at teaching the students. That is one aspect from a public point of view or from a professional point of view because they have been exposed to students that have been well educated. The other thing is that it is probably economic savings to faculty because they are not going to hire a faculty member to be on the unit with the students, so that means that they can have larger numbers of senior practicum students per faculty member.... It also keeps me and certainly other faculty members to be in touch with the reality of the nursing situation. The situation that nurses have to work in because you are in contact with the preceptors, you go into the units, you keep a journal, your students keep journals and you run them side-by -side in terms of what you teach and education of the students. (F2)

A preceptor confirmed:

> There are positive things to it. I have learned a lot from her too. When she asks me questions about things that I may not know the answer because I have been on this unit for two years, I make a special effort to find out and we both learn from it. (P4)

Another preceptor said of her experience with students:

> It depends on how willing they are to do things for themselves. I was lucky the students I had were willing to do that so they did well in those areas.... At the end of the time we did not have any intensive care patients so I will take a few patients and she will do the entire care with my supervision. (P2)

A student said:

> I hate to say this but after a while I was doing everything and that freed my first preceptor to talk, and to make the relationship with the patients that I really would have liked to have but I was so busy, getting medication and doing procedures and for her I thought that was really fortunate she was able to do that. (S5)

When preceptorship works, there are many benefits and satisfactions. Students experience the registered nurse's role and increase both competence and confidence. Preceptors have the satisfaction of nurturing young professionals and perhaps having time for providing better care to some of their patients. Competent students release preceptors

to gain additional knowledge and spend more time with patients. Faculty, when they choose to make the effort, can become more connected to the clinical setting. This greater connection can both increase teaching effectiveness and also yield insight into important nursing research questions.

Preparation of Preceptors

Preparation of preceptors emerged as a preceptor and a faculty category. None of the study participants ever had any form of training before assuming the preceptorship responsibility. All of the preceptors in the study thought some kind of educational preparation was essential for their role. Preceptors could be assisted in executing their role if faculty developed workshops in teaching methods, evaluation and other skills (Goldenberg, 1987/88). Preceptors made the following assertions:

> I have not been given any training ever since I have been precepting. I was only given a pamphlet to go through and what they had learned in class. I usually like going to these inservice courses. We have ---- inservice coming and I have applied to go. It is good to learn. I am getting older and I would like to learn more. (P1)

Another preceptor declared:

> We are doing instructor's work and the instructor goes to university and has long training. All of a sudden there we are thrown into it, not against our will. We are doing it and we need better skills to help out students. (P4)

A third preceptor concluded:

> Years ago I had a handout. It was mainly on what my role was but that was like 8 years ago. I have never seen anything as to what my role is, an orientation on what they want to do, what they expect of me. (P3)

A faculty member argued:

> I have heard of a four hour workshop for preceptors to learn how to be a preceptor. I guess you have to look at the situation and decide if that is necessary, even an hour, two or four hour orientation for the preceptor. It is really my concern. They should be paid for their time because if it is a day off related to work, they should be paid for that orientation. But a good package like a course outline, if they don't mind, they could read on their own.... I don't know whether they should have a course prior to being a preceptor. Because let us say there are 2000 nurses working in the hospital across the street. Are we going to put all the 2000 nurses through the program? You know if we really do 100 it could be a lot of money... so a package they can take home...very simple summary to the point... (F1)

I was amazed to learn from the preceptors that none of them have received formal preparation for the role they have assumed. Considering the fact that this university nursing program has been using forms of the preceptorship model for over a decade, attention to the education needs of preceptors seems warranted.

Reflections on Factors Influencing the Quality of the Preceptorship Experience

In this study, the roles of the preceptor from the perspectives of preceptors, students and faculty were identified. The findings have revealed congruency among the perceptions of faculty, students and preceptors regarding some crucial roles of the preceptor. In addition, positive and negative factors contributing to the preceptor experience have been delineated. Findings less related to the specific faculty /student/preceptor encounter and more to administrative details appear to influence the preceptor role as well.

It appears that there are no major differences in viewpoints among students,

faculty and preceptors on the preceptor role. Preceptors have expressed great concern about being given special preparation towards the fulfilment of the many roles they play in the clinical education of the final year student nurse.

It is clear that a preceptorship program is highly dependent on effective communication and good organization. While the program is organized for student benefit, in the long run preceptors benefit by having intrinsic rewards as well as improving themselves professionally. The educational institutions benefit from the program financially during this era of economic crisis. The health care institutions derive benefits such as provision of quality care to clients and access to graduate nurses with the potential to be excellent clinical nurses. Students, when optimal conditions exist, are socialized into professional nursing by excellent role models. The challenge is to develop conditions for preceptorship which will facilitate excellence. It is apparent that strategies for achieving such conditions still need to be developed. Attention needs to be given to the learning needs of preceptors, the investment of faculty in the process and the development of administrative structures which enhance communication and planning. Perhaps what is needed in Canada is less attention to researching what exists in terms of preceptorship and more focus on what could be. Action research, a research approach that is inherently collaborative, reflective and oriented to change, would be appropriate .

In the next chapter, findings presented in chapters four and five will be reviewed with respect to discussing the potential for development of a preceptorship model for nursing education in Ghana. This discussion will be framed within the context of the critique of knowledge transfer from countries of the North such as Canada to countries of

the South.

CHAPTER SIX

Relevance of Knowledge about Preceptorship in Nursing Education in Canada to the Ghanaian Context

In this last chapter, the issue of knowledge transfer from Northern to Southern countries is critically examined and connected to the knowledge gained from the research data on precptorship in nursing education in Canada. What value, if any, does the Canadian experience have for the planning of clinical experiences of student nurses in Ghana? It was my intention when I entered the graduate program to do historical research on nursing practice and nursing education in Ghana from the colonial era to the present day. I informed my sponsor, the Ghana Government, about my intent. To my surprise, I had correspondence from the Ghana Government that, if it were for a historical study, I would not have been sent to Canada because that could be done in Ghana. They expected me to do something *new* that would benefit the country. Students sent to study abroad are expected to come home with new knowledge that has relevance for the Ghanaian context.

In consultation with my supervisor, we conceptually explored nursing education in Ghana. Clinical education of nurses emerged as an issue facing nurse educators in both Canada and Ghana. We deliberated on how this issue is being resolved in Canada. Preceptorship was identified as one of the options. Conceptualizing preceptorship, I realised we have something similar to that in Ghana. I therefore decided to explore the

role of the preceptor in the Canadian context, critically review the findings and assess their applicability to the Ghanaian situation. This critical assessment of the preceptorship model in terms of its applicability for Ghana was done in awareness of issues relating to knowledge transfer from the North to the South.

The Issues Relating to Knowledge Transfer from Northern to Southern Countries

Knowledge transfer may be described as a process of applying previously acquired knowledge to a new problem or context. Pea (1987) suggests that knowledge transfer should not be viewed as a process of transferring common dominant elements as postulated by transfer theory. Knowledge transfer is not a simple individual matter, but a function of complex issues. Some of the issues are socioculturally rooted. Elements perceived by the thinker as common between the immediate and previous situations are comprehended according to the individual's culturally experienced classification system.

Transfer of knowledge from countries defined as being from the North to countries of the South usually involves the adoption of academic or practical instruction, theories or models derived from the research and experiences of Northern academics. Invariably, in the South, the cultural context, historical experience, economic conditions and political situations are quite different from that of the North where the knowledge was generated (Lee, Adams & Cornbletth, 1988). The Eurocentric bias of such knowledge, however, is seldom questioned. Ethnocentrism is insidious, particularly because it is often unconscious and thus not acknowledged. The justification for the

concept of knowledge transfer from industrialized nations to the Third World has generally been to solve the problems faced by the Third World. The predominance of the idea of the value of North-South knowledge transfer has been legitimized by the structural constraints imposed by international relationships on the Third World as a result of poverty. The popular viewpoint on knowledge transfer has been to assist in modernizing people who are not abreast with the modernization process (Stelck, 1994). Based on this assumption, the paradigm of knowledge transfer has therefore been from "centre to periphery" (Lee et al, 1988) in a paternalistic manner (Toh, 1996).

In an attempt to describe the knowledge transfer process, Lee et al (1988) identified three different knowledge systems which overlap each other in the process of knowledge transfer from the industrialized nation to the Third world . They suggested that there exist "The world knowledge system, an internationally structured system which may be divided into a central knowledge system and a periphery knowledge system; a centre knowledge system functioning in industrialized countries and influencing less-industrialised countries; and a periphery knowledge system located in a less-developed country and dependent upon a centre knowledge system" (p.234). Huberman and Levinson (1984) proposed that:

> Knowledge transfer relationships can be mapped descriptively in four elements: the generation of knowledge in the resource system, the transfer, the utilization of the transferred knowledge inside the user system and the communication of needs, concerns and reactions from the user system back to the source system knowledge. (p. 58)

They proposed that the transfer of knowledge be reciprocal, flowing in both directions. Usually, however, in the North -South context, the flow has been in one direction,

whereby industrialized knowledge is central and flows to the periphery in the Third World in a top-down manner. Historically, knowledge transfer has been manipulated as economic, social, political and cultural power (Stelck, 1994). Underlying this strategy has been the belief that western knowledge is the best.

This was evident in the administration of the early local universities and higher education institutions established in developing countries. The institutions were established as colleges affiliated to metropolitan Western universities (Bacchus, 1996). A typical example was the University of Gold Coast (Ghana) which was established in 1948 as a college of London University until 1968 when it attained full university accreditation from the British.

Lee et al (1988) observed, "Large investment in educational research tends to be found only in a handful of rich nations" (p. 243) and that made transfer of knowledge from industrialised nations, where it was developed, to the Third World imperative.The knowledge was perceived as legitimate because it had been scientifically proven. Third World scholars and professionals who were educated in Northern institutions were indoctrinated to the ideas and methodologies of industrialised nations. Without questioning their applicability and utility in the Third World, they embraced the ideas and the transferred knowledge was seen as authentic internationally, requiring no modification at the periphery (Lee et al, 1988). Other channels of knowledge transfer besides education included publications, government or state protocols, international agencies like the World Health Organization, missionaries, voluntary workers and, more recently, the World Bank (Toh, 1996) . Volunteer services, especially in the early sixties,

led to many youths from industrialized countries flooding Ghana, predominantly in educational institutions, giving educational assistance. The scholars from the South were looked down upon and their intellectual abilities questioned by scholars from the North. The interaction between the scholars at the centre and the ones at the periphery was hierarchical in nature and reinforced perceptions of inequality. The scholars at the periphery, lacking self confidence, felt drowned in a pool of inferiority complex (Lee et al, 1988). This has been vividly described by Toh (1996):

> In the earlier phase, the interaction between North and South tended to be hierarchical, with the North dictating the goals, content, pace and methodologies. Some of us may have experienced or heard stories of the expert or advisor who arrogantly professes to know everything and treats local counterparts as if they know little or nothing and are expected to implement passively the "expert" advice. Such unequal North-South interactions have also occurred in the context of volunteer agencies and nongovernmental organizations. We may have come across professors who see international (especially South) students as empty receptacles to be filled with the "valuable" knowledge of the North that is "indispensable" for economic growth and other facets of modernization. Some expatriates have been known to demand privileges that set them apart from local peers, living in comfortable and culturally isolated communities with impermeable boundaries and assuming an attitude of superiority vis-a-via local cultures, knowledge, and tradition. (p.p. 179-180)

Western knowledge continued to dominate Southern nations in an unquestioned way for decades. Nevertheless, of late, the Southern nations have begun to examine and question the assumptions underpinning some of the imported knowledge and the extent to which such knowledge is relevant within local contexts.

Changes Occurring

Almost all developing nations have obtained their independence and this has created sudden awareness of self-worthiness. The last few decades to the close of the century are seeing a change in North-South relationships from hierarchical interaction to more horizontal communication within partnership models. Toh (1996) has observed:

> As the decades went by, however, an increasing number of practitioners, analysts, and policymakers have been open to the lessons of both failed and positive interventions. Also, the tone of global political culture has been changing such that South nations and actors are no longer willing just to listen and follow. (p.180)

South nations are gaining mutual recognition in decisions concerning them. Industrialized nations have began working together with Southern nations and the notion of seeing the South nations as "Tabula Rasa" is gradually dying out and is being replaced by collaborative or team approaches to solving Southern problems. The culture, the view points, and the experiences from the South are given credence. Now the slogan in vogue is *partnership* (Toh, 1996). Masemann (1990) predicted: "The knowledge hierarchy that evolved from mercantilism, imperialism, and colonialism will crumble, just as the totalitarian regimes of Eastern Europe have crumbled in the face of popular demand for freedom of expression" (p. 472). Rust (1991) proposed a remedy:

> The solution should not be to reject all metanarratives, trapping us into localized frameworks that have no general validity, that disallow comparison, and that deny integration of cultures and harmoninizing values. Legitimate metanarratives ought to open the world to individuals and societies, providing forms of analysis that express and articulate differences and that encourage critical thinking without closing off thought and avenues for constructive actions. (p. 616)

The change is prevalent in almost every country as the hitherto unchallenged North

economies now depend largely on economic transactions with the South and are consequently compelled to pay some attention to the voices of the South. It is within this framework of critical evaluation of North-South knowledge transfer that the applicability of the findings of this study to the Ghanaian context will be discussed.

The Case: Introduction of Preceptorship in Ghana

The North colonized the majority of the South nations, and Ghana was no exception. Ghana was colonized by the British, until 1957 when she attained her independence. The British controlled education and development through economic dependency; hence education was directed towards training for capitalism and modernization as perceived from the Western knowledge base. Nursing education was no exception to British indoctrination.

Formal nursing education in Ghana was fashioned after the British system. Following Ghana's independence, many of the nurses were sent to England to be prepared for leadership roles. Even now, nursing education in the country continues to use foreign textbooks. The information contained in many of the textbooks is culturally biased towards their places of publication. Consequently, some of the information is out of context to the Ghanaian situation. Yet no provision has been made for changes. For example, nursing students are taught to make beds with woolen blankets and to serve a patient with a "warm" bed pan in a hot tropical climate like Ghana. These examples depict some of the problems that exist in imported knowledge. Students are instructed and

examined on such an illogical basis. Nursing education still continues to rely on Western knowledge. Nursing consultants have often been brought from industrialized countries with knowledge was that was transferred into the profession in Ghana with little or no modification made for the cultural context.

Although the curriculum for training nurses has gone through transition from British to American in recent years, the graduates from the program are still found wanting in light of meeting the health needs of the society. This could probably be attributed to the fact that the Ghanaian cultural heritage, although adulterated to some extent, still has great impact on the society particularly in rural Ghana. Similar observation was made in Uganda by Stelck, (1994). Traditional knowledge is still adhered to, especially in rural Ghana where 75% to 80% of Ghanaians reside. Traditional knowledge is manifested by adhering to extended family system, high parity rate among women, compound housing, manual agriculture, and the non-formal health care system just to mention a few. The existence of traditional knowledge in the field of health is supported by the fact that 75% of births in Ghana are conducted by traditional birth attendants and 50% of Ghanaians use herbal preparations as a first choice for self medication when they fall ill (Minister of Health's Report, 1995).

Recently, students have questionned some of the content in the nursing curriculum in Ghana. This is a warning sign that new information, or techniques discovered by scholars from the South in their study abroad, should not be uprooted for planting in the Ghanaian system. One must reflect on the applicability of that information/technique to the Ghanaian nursing context, including its sustainability and

viability as well as its benefit to the nursing profession or health of the population as a whole.

As previously stated, preceptorship is a one-on-one learning experience in the clinical setting whereby the student is paired with a staff nurse who guides the student. The practice in Ghana is to attach the student to a unit without naming a specific nurse as preceptor. Thus, while staff nurses in the clinical setting assist with clinical preparation of students, the roles have not been defined or recognized and accountability for student learning is diffused among all staff. I am looking forward to modifying the present scenario in Ghana. It is hoped that each student would be attached to one staff nurse who will be responsible for the learning needs of the student. The student will run parallel time, work the same shift as the staff nurse and the staff nurse will give continuous evaluation as well as summative evaluation of the student's performance at the end of the preceptorship relationship. Factors that enhance or impede preceptorship have also been identified and their applicability to the Ghanaian situation will be explored through a pilot action research project on preceptorship that I hope to conduct in Ghana.

It is conceived that an action research approach would be an appropriate approach to implementing a preceptorship model in the Ghanaian setting. Action research aims at researching with the people rather than researching on them (Simmons, 1995). This research methodology addresses the problem right on the spot and also ensures active participation of the staff from identification of the problem through data collection, analysis and discussion of findings. When front line staff are made to actively participate in research, they can appreciate the relevance of the research findings to their practice. It

gives them the opportunity to gain new insight, identify new knowledge, discern what they have been doing and then think of other ways of doing things (Pearcy & Draper, 1996). Hayes (1996) explained "The unique part of action research is the involvement of the stakeholders in setting priorities for decisions and actions in which they are involved" (p. 3). Thus action research helps to curb the old notion of "non-implementation" of research findings which is very prevalent in nursing (Simmons,1995). This research methodology also enhances the relationship among educators, researchers and practitioners just as it bridges the gap between the North and the South by breaking the hierarchical barriers and providing the grounds for working in partnership with one focus.

Why, after conducting this research on preceptorship in the Canadian context in nursing education, do I believe that such a practice would strengthen nursing education in Ghana? My reflection on this question will be presented in the remainder of this thesis.

Preparing competent nurses for the 21st Century is a major concern of nurse educators in Ghana because of the current deficiencies in clinical education. Innovative clinical teaching that is cost effective is desired. An extensive review of the literature on the clinical education of the nurse show that the preceptorship model is a common choice in North America, Australia, and more recently, in Europe.

There is no way that any of the nursing institutions in Ghana as currently organized can provide that one-on-one experience that the preceptorship model provides for students. The preceptorship model may have its disadvantages but so far it is the one that has been adopted by nurse educators in North America and in Europe where

Ghana consults for advice regarding improvement in the health care delivery system. The preceptorship model, apart from being cheap, appears to focus on individualised teaching/learning and there is evidence that it can be as effective as the model of having student nurses supervised by nursing faculty (Peirce, 1991). The model provides opportunity for cooperation and collaboration between nursing education and nursing service. It acts as a catalyst, fostering on-going learning in practising nurses which results in improved and better patient care. Ghanaian nurses would be challenged in many of their routine practices as they assumed the responsibility of working on an individual basis with specific students. This could raise the standard of nursing care in the country.

Reflections on the Concept of Preceptorship in Reality of the Ghanaian Context

I have been reflecting on what the primary roles of the preceptor as identified in the study would mean to staff nurses in Ghana and how they would react to these roles. Although some staff nurses have been helping students in the clinical setting, their roles were never identified and they were not accountable to anybody. Based on the study findings, five primary roles of the preceptor have been illuminated by the three cohorts. They are role modelling, supporting and building confidence in students, teaching and evaluating students and future job possibilities for students. Looking at these primary roles from the Ghanaian context becomes a big issue. Using the teaching role of the preceptor as an example, some staff nurses in Ghana already assist with clinical teaching of students. They are not, however, held specifically accountable for the teaching and learning needs of a specific student. How assuming this responsibility would be perceived

is a critical concern. The first foreseeable reaction would be "I am not an instructor, I am not trained". I have this hunch because I have on several occasions heard the statement, "Wait until your tutor comes and you can ask her that question" from some staff nurses to students who were curious about knowing certain clinical things. This is because some of the staff nurses have little theoretical orientation in their area of practice (Thorell-Ekstrand et al, 1993). As in Canada, staff nurses do not want to guide students inappropriately.

Another important point in Ghana is nursing practice is not keeping pace with nursing education . An example to support this statement is the use of the nursing process and an orientation towards individualised patient care. Both have been recognized by the nursing profession and have been taught to students in Ghana since the transition from the Nightingale's system of training to the comprehensive nursing program in 1970. I cannot point out any particular unit that has effectively implemented the nursing process in Ghana (Opare, 1985). As a Ghanaian nurse with clinical experience in England and in a graduate program in Canada, I believe that such practices would enhance patient care in Ghana.

The evaluation role of the preceptor would be another difficult role for staff nurses in Ghana to assume. The cultural setup makes it difficult for people to be upfront in giving a negative judgement about others. If it is a positive judgment there would be no problem but, in a case of an unsafe student, a staff nurse would encounter a dilemma. People do not want to be blamed for others' misfortunes. There have been several instances where students have misbehaved in the clinical setting in ways that might have

resulted in the termination of their course but the clinical staff who were eye witnesses to the incidents would not report the case to the school. Even in some instances that the school got to know about it, and wanted confirmation from the clinical staff, they often denied having witnessed the incident. Culturally, people do not usually tell on others and this has proliferated into the profession. Secondly, there was the fear that the student might be terminated as a result and the person would be guilty of having caused a break in "somebody's daughter's" career. That person might feel guilty for the rest of her/his life for having participated in the evaluation process. Many nurses are vocal but, when it comes to documentation, may find it difficult to document something that might adversely affect a student. They would prefer that the instructor do the evaluation. Even some instructors, for the sake of personal peace, would not want to fail students because failing a student is not a matter of the individual student. It often becomes a complex political issue where families, politicians and chiefs contest the failure. In Canada this is equally an issue as explained by a faculty member:

> It is really very hard for a preceptor if she has to fail a student because they feel they have somehow not done their job.... If the preceptor and the instructor feel that it is just more experience that the student needs, usually what we do is find another unit and another preceptor to instruct the student afresh. If the student has been tremendously unsafe and we have examples of that, we take the student right out and she/he fails.... It takes tremendous documentation and the student can appeal. (F4)

However, I think both preceptors and faculty members go through a lot of anguish when a student fails clinically in Canada. A preceptor narrated her personal experience when she had to fail a student:

> But you could not help crying, knowing how much this girl's whole future has

> been influenced by the word you put on paper. So that will be the worse thing. No, I have done it only once. (P5)

A faculty member explained how preceptors are supported in unpleasant situations like that:

> The clinical instructor has to spend a lot of time to work with the preceptor and say, "No you did what you could and what you have done is really valuable. Thank you for this because we need to get the student extra clinical". We then take the student away from the preceptor and plan a next clinical for her. (F4)

Without faculty support, preceptors have great difficulty evaluating students who they consider poor or unsatisfactory. The decision to fail a student is usually perceived as a faculty responsibility. Preceptors, however, collaborate in the evaluation process. (Lewis, 1990). This model will be proposed for the Ghanaian situation.

The other two primary roles (role model and support and confidence building) may not pose problems. The support giving role may be particularly easy because of the concept of the Ghanaian cultural norm of fostering interdependency. People wish to share food, shelter or knowledge gained and this permeates throughout the extended family system. People tend to relate to each other as brothers and sisters even at work places. To some extent this is healthy but it might be a source of conflict when evaluation of students is an expectation. Another factor is that, in Ghana, people are never on first-name-terms. The junior nurse would always address the senior nurse as "sister" before her first name. Addressing someone as a "sister" is a symbol of respect and the senior nurse feels obliged to support the junior nurse in return. A supportive environment enhances confidence and competence (Young et al, 1989). As mentioned earlier, as part of the support, the clinical staff, especially staff nurses, would not want to

give any adverse comments about students to instructors. With regards to the role modelling aspect of the preceptor role, one faculty member in my study said:

> Because a lot of the work we are doing is role modelling. The registered nurse role models for the students help or assist them with care planning or how to communicate in the clinical setting. Also helping them with problem solving or if you just give them an answer...they would move so that by the end of the fourth year they were very confident clinically. (F4)

This implies that the staff nurse is automatically a role model once she presents her/himself in the health care situation. She/he can be a good or a bad role model. However, the majority of the nurses in Ghana strive to be good role models of the profession because nobody is an individual in the Ghanaian society. Everybody comes from a family and everything is viewed from the family context. The family is the focal point and nobody would want to cast a slur on her/his family. Hence, greater numbers of staff nurses can be perceived as being good role models to students. Many unit managers provide references for students who have worked in their units when the student wants to apply for further study or promotion. In Ghana, the majority of the nurses are automatically absorbed into the working system by the Ministry of Health as soon as they are qualified. Active searching for job opportunities, as required by new graduate nurses in Canada, is not an issue for nurses trained in the hospital schools of nursing. Searching for job opportunities is, however, a big issue for nurses educated in the baccalaureate program because their program is under Higher Education and not under Ministry of Health like the hospital programs.

Implementing the role requirements for preceptorship is not beyond the capability of practising nurses in Ghana. While orientation would be required, the transition from

faculty guided or apprenticeship models would not pose insurmountable problems. The issues related to preceptorship as discussed in chapter five may, however, pose substantial difficulty.

Why Preceptorship Might Work in the Clinical Education of Student Nurses in Ghana

Clinical education of nursing students has been of concern to both nurse educators and nurse administrators. The Ministry of Health, which is the major financier of nursing education programs and employs great numbers of graduates, shares this concern. There has been discussion in chapter one on measures adopted by the Ministry of Health to improve the clinical skills of newly graduated nurses since the transition from the apprenticeship model of training in 1970. It would be useful to pilot test a preceptorship project, adopting an action research approach, and evaluate what happens.

Preceptorship facilitating and impeding factors as well as ancillary findings identified by the study groups have prompted me to form a mental picture of issues that might be associated with preceptorship program implementation in Ghana. I can see clearly that the success of a preceptorship program is highly dependent on effective communication and good organization. Preceptor commitment becomes a crucial factor to the success of the relationship. Preceptors in the study were committed to their roles and did not put any emphasis on monetary or material gains for the service they rendered. Many of them were content with a "Thank You" note as appreciation for their efforts.

In Ghana, perhaps related to the high cost of living and low salaries, people are

highly money conscious. One cannot expect staff nurses to give free service because preceptors invest time and energy into the preceptor role. I am wondering how staff nurses in Ghana would react to giving free "committed" service for a token gift like a pin or a "thank you" note. It is my conviction that if preceptorship were to be implemented and sustained in Ghana, one would have to find ways and means of giving adequate incentives to staff nurse preceptors. The cultural value of "sharing", while widely practiced, has limitations. This would call for a formal administrative intervention from the Ministry of Health to support the preceptorship program by designing a meaningful reward for nurse preceptors. This could take the form of an incremental jump on the salary scale for nurse preceptors or funds made available for paying preceptors after each session of precepting. The Ministry of Health would have to be convinced about the cost effectiveness of preceptorship before becoming committed to the program. Gathering such data could be difficult as it relates to quality of outcomes and thus poses measurement issues.

Barriers like poor communication could be minimized by appointing a faculty member and a nursing service member as preceptor coordinators to be responsible for administrative duties and to provide liaison between nursing education and nursing service. This would enhance adequate collaboration (Lewis, 1990; Yonge & Profetto-McGrath, 1990). To ensure commitment of unit supervisors to the program, their participation would be encouraged by involving them in planning the program to suit the Ghanaian context.

Strategies for Implementation

Individual Level

The importance of good communication networks has been stressed in the literature (Lewis, 1986; Thorell-Ekstrdnd et al, 1993) as being crucial for successful preceptorship. Individual level communication and lobbying would be an essential component. Caution is needed in doing this groundwork of selling the idea of preceptorship to the policy makers and influential people in the health care delivery system. The Director for Human Resources Development Division will need to be convinced about the cost effectiveness of preceptorship. The Chief Nursing Officer and the Registrar for Nurses' and Midwives Council (who is responsible for training and registering of nurses in Ghana) will need to be contacted in the initial phase and be orientated to the high quality client care that is provided by a good preceptor program. I will consult with my nurse educator colleagues on an individual basis to convince them of how a well organized preceptorship model can enhance students' acquisition of clinical knowledge and hands-on skills. The idea will be sold to nurse administrators, staff nurses and senior student nurses. Without their interest and support, the idea is likely to be rejected.

Professional level

As a strategy for implementation of preceptorship, I have had an article accepted for publication which is entitled "Nursing Preceptorship: Could it be the Answer?"

(Opare, 1996; in press to be published in the West Africanican Journal of Nursing). This is the official publication of the West African College of Nursing. This journal is read by nurses in Ghana as well as nurses in all of the English-speaking West African countries. In the article, the potential benefits of preceptorship are described. The majority of nurses do not know what preceptorship is and I was unaware of the strategy before coming to Canada. This will be one means by which to inform my colleagues. I hope to consult with the inservice education department of the Korle-Bu Teaching Hospital and discuss preceptorship with staff nurses during their inservice education sessions. Presentation on preceptorship will be made to groups like the Nurse Educators Group, the Ghana Registered Nurses Association and as many other small nursing groups as possible.

Workshops and inservice education on preceptorship will follow once a proposal for implementation has been approved and funded by the Human Resources Development Division. Workshops to enhance nurse educators' support for the program will emphasize communication. Educators must acquire the habit of keeping in touch frequently with preceptors and students and also encourage them to contact them whenever necessary. They must make themselves available in the clinical setting and maintain closer ties with practical realities. It was found in this study that students are treated better by service staff when faculty is in frequent touch with clinical setting. From my interviews, I learned that often there were gaps in communication between service and educational institutions. In Ghana, there have been instances when students were asked to go back to the school because the unit was not expecting them. With the implementation of preceptorship, proper communication networks will have to be established between the

service and educational institution by having preceptorship coordinators, who will be people selected from education and service institutions. They will execute the administrative duties such as writing letters to the units and preparing information booklets for preceptors and students (Yonge & Profetto McGrath, 1990). This will enhance mutual sharing of information and resources.

Other components of the educators' work shop will be on students' readiness for preceptorial experience. Educators need to ensure that students are well prepared before sending them to preceptors. In the study a faculty member warned:

> My advice will be not to take advantage of preceptors. Don't give them a student that you have not already prepared at least in the laboratory, with knowledge, with theory or with some practice. The student must go out having the thought and hands-on in that practice area. Don't expect the preceptors to it because they will say, "What am I supposed to do? Teach a whole course now?" They get angry when they are treated like that. Never send students that have not had the preparation that they need for that particular area. Preceptors get really annoyed if they ask them questions constantly that they should have been taught or they could look up for themselves. (F4)

Faculty commitment in Ghana might not be an issue because preceptorship is likely to be a relief to the overburdened instructors. The large student-instructor ratio in the cilinical area stimulated me to undertake this project. I expect that instructor commitment for the preceptorship program will be gained easily and the necessary precautions will be taken by instructors to nurture preceptors.

Who is to precept?

Recruitment of preceptors will be done by faculty in consultation with administrators who would be asked to submit the names of competent nurses. This strategy may help overcome the difficulties that occur when staff nurses precept because they have been asked to do so by their unit managers. It has been observed from the study that when preceptors are asked by their unit manager to precept, some nurses may feel coerced and unable to decline the offer. This has resulted in unpleasant experiences for students when preceptors did not want students but felt unable to refuse. Nonetheless, it will be difficult to differentiate those nurses who want to precept genuinely from those who might have other motives for taking students. One often cannot ascertain the different values and expectations of nurses willing to participate. A preceptor nomination form will be signed by selected preceptors to acknowledge their willingness to precept. Other criteria will be a minimum of one year of experience in the clinical practice area.

Preceptor Preparation

The study finding that none of the preceptors was trained will not be the *modus operandi* in Ghana. Preceptor workshops will be conducted by faculty for the selected preceptors. This is important because clinical nurses have no formal teaching experience and since this is the introductory phase of the preceptorship model and there are no other nurses with preceptorship experience for the preceptors to turn to for guidance, special preceptor preparation is imperative. It is hoped that preceptors will be trained in the roles

and functions of preceptors (clinical teaching methodologies, decision making, and feedback-evaluation) and new concepts in clinical practice (Myrick,1988). This will build their confidence and equip them for the expected roles. Also, presenting to staff nurses some of the benefits that preceptors get might be inviting to them. One preceptor in the study acknowledged how students help:

> But she has been like an extra pair of hands that we wouldn't have got when we needed it. At the end of the night shift last week everybody appreciated her work and everyone was saying "Thank you" to her because she did so much. She was really of good help to us. (P3)

And a faculty member shared her experience:

> Once a student is operating at a higher level that preceptor is not going to work quite so hard so it sort of probably balances it out. A lot of places do like to have students because they always work hard as much as nurses and you know how short the staff is. So once they pass that orientation period they like to have them just because they can help. (F2)

Staff nurses will be made aware that they can decline or take a break when they want. The action research approach may kindle staff nurses' interest in the preceptorship model. With these and other benefits such as professional recognition, professional growth and some other incentives, it is hoped that staff nurses will be receptive to precepting students.

It has been acknowledged from this study that the influence of unit managers greatly affects preceptorship. It is therefore crucial that this group of people are also given some preparation in the form of a workshop with a different focus from that of the preceptor preparation. Their preparation will focus on organization of the learning environment and how to support the preceptors.

Evaluation

Evaluation of the preceptorship model will be enhanced through action research as soon as the program is initiated and the findings from the research will be used to modify the program. Follow-up study of students one year after graduation from the preceptorship program will prevail. Instructor, preceptor and institutional performance in the process will be evaluated.

Final Thoughts

Implementing a preceptorship program in Ghana will not be easy. It will involve all aspects of management (planning through organization, directing to controlling). Excellent interpersonal skills, the ability to lobby for inputs, and selling the idea to influential people in nursing and the health care services will be major challenges. Through focus and perseverance, however, it is possible. I also believe it is desirable and that transfer of this approach to clinical education in Canada to the Ghanaian context will enhance the clinical skills and knowledge not only of new graduates but also of currently practising nurses. Connections between nursing education and nursing practice, an ongoing challenge in both Ghana and Canada, could be strengthened.

Knowledge gained regarding preceptorship in nursing education in Canada will be used in planning for the pilot project in Ghana. This knowledge, however, will be considered a guide. All changes will have to be made in full cognizance of the Ghanaian situation. Direct transfer of knowledge, without consideration of contextual differences,

would be replicating activities of our colonial past. What is needed is thoughtful modification and application of knowledge in which cultural and other differences are made conscious and factored into all decisions.

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APPENDIX A

INFORMATION LETTER TO FACULTY

Project Title: Perceptions of the Role of the Preceptor in the Senior Student Nurse Practicum.

Researcher: Mary Opare, MN Student, Phone: 492-6685 (office), 437-0255 (home).
Thesis supervisor: Linda Ogilvie, RN, PhD.

I have been a graduate student in the Faculty of Nursing at the University of Alberta for the past year and a half. During that time, I have become aware of the use of experienced nurses as preceptors in the clinical component of some nursing courses.

The clinical experience of student nurses in my home country of Ghana is of concern to me as questions about the competence of new graduates have been raised. For my thesis, I am planing to interview faculty, students and preceptors who have experience in Nursing 403/404 medical-surgical sections as to their perceptions of the preceptor role and the factors which promote or inhibit the success of the preceptorship experience.

I would like to meet with you to discuss this project and your possible assistance with it. What I need is entry into the system for identification of potential participants. You have been identified as a faculty member who could help in at least one of the following ways: (1) accessing students; (2) accessing preceptors; or (3)being interviewed as a faculty participant for the research.

I am interested in the medical-surgical practicum as my experience in nursing education in Ghana involves teaching that subject. My hope is that the knowledge gained from this research will be used to initiate a pilot project on preceptorship in Ghana after I have returned home.

If you are willing to discuss helping me in any of the three areas described, please contact me at Phone # 492-6685 or leave a note in my mailbox at the Faculty of Nursing.

Sincerely,

APPENDIX B

INFORMATION LETTER TO PRECEPTORS AND STUDENTS

Project Title: Perceptions of the Role of the Preceptor in the Senior Student Nurse Practicum

Researcher: Mary Opare, MN Student (phone: # 492-6685)

Thesis Supervisor: Linda Ogilvie, RN, PhD.

I have been a graduate student in the Faculty of Nursing at the University of Alberta for the past year and a half. During that time , I have become aware of the use of experienced nurses as preceptors in the clinical component of some nursing courses.

The clinical experience of clinical nurses in my home country Ghana is of concern to me as questions about the competence of new graduates have been raised. For my thesis, I am planning to interview faculty, students and preceptors who have experience in Nursing 403/404 medical-surgical sections as to their perceptions of the preceptor role and the factors which promote or inhibit the success of the preceptorship experience.

This letter is being sent to you by a faculty member who has identified you as someone who has the experience needed to participate in the project. I do not know who has received these letters. What I am looking for are students and nurses who are willing to be interviewed twice about their thoughts on the preceptorship role and the factors which influence the success of the preceptorship experience. Interviews will last about one hour, will be arranged for times and places convenient to you, and will be tape-recorded. Your participation in the project will be kept confidential. You may choose not to answer questions or to withdraw from the study at any time.

I am interested in the medical-surgical practicum as my experience in nursing education in Ghana involves teaching that subject. My hope is that the knowledge gained from this research will be used to initiate a pilot project on preceptorship in Ghana after I return home.
If you are willing to be interviewed for this study, please contact me at phone # 492-6685 (office) or 437-0255 (home).

Sincerely,

Mary Opare.

APPENDIX C

GUIDING QUESTIONS FOR INTERVIEW

Areas to explore

1. Perception of Preceptor Role

2.Factors Influencing the Success of a Preceptorship Experience

3. Advice for Developing a Preceptorship Program for Nursing Education in Ghana

4. Any Further Thoughts Participants Would Like Share

APPENDIX D

DEMOGRAPHIC DATA

CODE...

DATE...

GENDER FEMALE MALE

AGE

- 20-30
- 31-40
- 41-50
- 50+

Years of Experience in Nursing

- 1-3
- 4-6
- 7-10
- 11+

Professional Education

- Masters Prepared
- Baccalaureate
- Diploma

APPENDIX E

CONSENT FORM

Project Title: Perception of the Role of the Preceptor in the Senior Student Nurse Practicum

Investigator: Mary Opare, MN Student, Faculty of Nursing, University of Alberta (phone: # 492-6685)

Thesis Supervisor: Linda Ogilvie, RN, PhD. Faculty of Nursing, University of Alberta

The purpose of this research is to find out how preceptors, students and faculty view the role of the preceptor in the clinical education of student nurses.

Participation in this research will include being interviewed twice, with the possibility of a follow-up telephone conversation to confirm the interpretation of information. Each interview will last approximately one hour and will be audio-taped.

There will likely be no harm to you if you participate in this research , nor will you likely benefit directly from this study. Results from this study will help the researcher develop a system of preceptorship for nursing education in Ghana.

You do not have to be in this research if you do not want to be. If you decide to be in the research you may drop out at any time by telling the researcher. You do not have to answer any questions or discuss any subject in the interview if you do not want to.

Your name will not appear in this research/study. Only a code number will appear on any form or question sheets. The researcher will erase your name and any other identifying material from the transcription of the tapes. All tapes, transcriptions, and notes will be kept in a locked cabinet separate from consent forms or code list for seven years after completion of the research/study. Consent forms will be kept for at least five years. Data may be used for another research study in the future, if the researcher receives approval from the appropriate ethics review committee.

The information and findings of this research study may be published or presented at conferences, but your name and any material that may identify you will not be used. If you have questions or any concerns about this research study at any time, you may call the researcher at the number above.

CONSENT: I acknowledge that the above research procedures have been described. Any

questions have been answered to my satisfaction. In addition, I know that I may contact the person named below, if I have further questions either now or the future.
I understand the possible benefits of joining the research/study, as well as the possible risks and discomforts. I have been assured that the records relating to this study will be kept confidential. I understand that I am free to drop out at any time. I have been given a copy of this form to keep.

_____ _____
(Signature of Participant) (Date)

_____ ----------

(Signature of Researcher) (Date)

REQUEST FOR SUMMARY:

If you wish to receive a summary of the study when finished, please complete the next section:

Name:----------

Address:----------

University of Alberta
Edmonton
Canada T6G 2G3

Faculty of Nursing
3rd Floor Clinical Sciences Building

Certification of Ethical Acceptability for Research Involving Human Subjects

---

NAME OF APPLICANT(S): Mary Opare, MN Candidate

TITLE OF PROJECT: "Perceptions of the Role of the Preceptor in the Senior Student Nurse Practicum"

The members of the review committee, having examined the application for the above named project, consider the procedures, as outlined by the applicants, to be acceptable on ethical grounds for research involving human subjects.

Mar 28, 1996
Date

Janice Lander, PhD
Chair, Ethics Review Committee

ERC 96-077
5005-02-077

University of Alberta
Edmonton
Canada T6G 2G3

Faculty of Nursing
Office of the Dean
Third Floor Clinical Sciences Building, Telephone (403) 492-6236
Fax (403) 492-6029
E-mail: mwood@ua-nursing.ualberta.ca

March 28, 1996

Mary Opare, MN Candidate
Faculty of Nursing
University of Alberta

Dear Ms. Opare:

This letter is your authorization to contact Faculty of Nursing students for the purpose of requesting their voluntary participation in your research study "Perceptions of the Role of the Preceptor in the Senior Student Nurse Practicum", which has received ethical clearance from the Faculty of Nursing on March 28, 1996.

Sincerely

Marilynn J. Wood, RN, DrPH
Dean and Professor

MJW:sk

Capital Health Authority

Regional Research Administration Office
WMC 5C2.16, 492-1372

Memorandum

NOTICE OF APPROVAL FOR PROPOSED RESEARCH
UNIVERSITY HOSPITALS SITE

Project Title:	Perceptions of the role of the preceptor in the senior student nurse practicum.
Project No.:	O-06
Investigator(s):	Ms. Mary Opare
Department:	Faculty of Nursing
Division:	
Address:	3rd Floor, CSB
Phone/FAX:	492-9109/

Supporting documents:

1)	Ethical Approval	March 1996, Faculty of Nursing
2)	Study Protocol	Received
3)	Funds:a) Source	P.I. will fund.
	b) Type	N/A
4)	Overhead Negotiated	N/A
5)	Account #	N/A
6)	Contract	N/A

Project Approved May 1996

THIS APPROVAL IS VALID FOR ONE YEAR

By

Title

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